## Filing at a Glance

| | |
|---|---|
| Company: | Colorado Choice Health Plans |
| Product Name: | Colorado Choice - Individual Market |
| State: | Colorado |
| TOI: | HOrg02I Individual Health Organizations - Health Maintenance (HMO) |
| Sub-TOI: | HOrg02I.005D Individual - HMO |
| Filing Type: | Rate |
| Date Submitted: | 05/15/2013 |
| SERFF Tr Num: | MLCO-129025213 |
| SERFF Status: | Closed-Filed |
| State Tr Num: | 278052 |
| State Status: | Filed |
| Co Tr Num: | |
| Implementation Date Requested: | 01/01/2014 |
| Author(s): | Travis Gray |
| Reviewer(s): | Cathy Gilliland (primary), Nichole Boggess, Michael Muldoon, Amy Filler, Rachel Plummer |
| Disposition Date: | 08/01/2013 |
| Disposition Status: | Filed |
| Implementation Date: | 01/01/2014 |

State Filing Description:
SERFF Binder Filing: MLCO-CO14-125001226

***State:*** *Colorado* ***Filing Company:*** *Colorado Choice Health Plans*
***TOI/Sub-TOI:*** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
***Product Name:*** *Colorado Choice - Individual Market*
***Project Name/Number:*** */*

## General Information

Project Name:
Project Number:
Requested Filing Mode: File & Use
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Travis Gray

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 08/01/2013
State Status Changed: 07/30/2013
Created By: Travis Gray
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions:

All individual market plans listed here will be sold on the exchange.

Filing Description:

This is the rate filing for Colorado Choice Health Plans for products to be offered in the individual market in 2014. These plans will be offered both on and off Connect for Health Colorado.

State Narrative:

Rate Change Summary
Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).

Both On and Off Exchange Plans
Gold: 3 plans
Silver: 5 plans
Bronze: 3 plans
Catastrophic: 1 plan

## Company and Contact

### Filing Contact Information

Travis Gray, ASA, MAAA, Associate Actuary
1400 Wewatta Street
Denver, CO 80202-5549

travis.gray@milliman.com

303-299-9400 [Phone]

***State:*** *Colorado* ***Filing Company:*** *Colorado Choice Health Plans*
***TOI/Sub-TOI:*** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
***Product Name:*** *Colorado Choice - Individual Market*
***Project Name/Number:*** */*

### Filing Company Information

(This filing was made by a third party - millimanco)

| | | |
|---|---|---|
| Colorado Choice Health Plans | CoCode: 95774 | State of Domicile: Colorado |
| 700 Main Street, #100 | Group Code: | Company Type: |
| Alamosa, CO 81101 | Group Name: | State ID Number: CO |
| (719) 589-3696 ext. [Phone] | FEIN Number: 23-7296258 | |

## Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

## State Specific

Please enter state-specific code(s) found in Colorado's Filing Requirements Bulletins, or on the General Instructions page. Please list all applicable state-specific codes. If no codes are applicable, please enter N/A.: 645 Non-Grandfathered PPACA
All rate and loss cost filing types MUST be submitted with completed Rate Data Fields in accordance with Sections 10-4-401 and 10-16-107 C.R.S. This requirement does not apply to form filing types. Rate and loss cost filings not including this data will be rejected. If this is a rate or loss cost filing, have these fields been completed?: Yes
Have you completed the Forms Schedule Tab? ALL Life, Accident, and Health Rate and Form filing types require the Form Schedule Tab to be completed. In addition, all Form, Annual Form Certification, and Refund Calculation filing types require the Form Schedule Tab to be completed. The actual form must be attached to Form filing types only when filing: Medicare Supplement, Long-Term Care Partnership, Stop Loss, P&C Summary Disclosure Forms, and Workers Compensation. It is not necessary to submit the actual form for other lines of insurance. Thank you.: Yes

**SERFF Tracking #:** MLCO-129025213 **State Tracking #:** 278052 **Company Tracking #:**

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Filed | Nichole Boggess | 08/01/2013 | 08/01/2013 |

## Objection Letters and Response Letters

### Objection Letters

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Pending Industry Response | Rachel Plummer | 06/14/2013 | 06/14/2013 |
| Pending Industry Response | Cathy Gilliland | 06/05/2013 | 06/05/2013 |
| Pending Industry Response | Michael Muldoon | 05/27/2013 | 05/27/2013 |
| Pending Industry Response | Cathy Gilliland | 05/21/2013 | 05/21/2013 |
| Pending Industry Response | Cathy Gilliland | 05/15/2013 | 05/15/2013 |

### Response Letters

| Responded By | Created On | Date Submitted |
|---|---|---|
| Travis Gray | 06/19/2013 | 06/19/2013 |
| Travis Gray | 06/11/2013 | 06/11/2013 |
| Travis Gray | 06/03/2013 | 06/03/2013 |
| Travis Gray | 06/03/2013 | 06/03/2013 |
| Travis Gray | 06/11/2013 | 06/11/2013 |

## Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Rate | Rating Manual - CCHP Individual Market (Updated 7-29) | Travis Gray | 07/29/2013 | 07/29/2013 |
| Supporting Document | Actuarial Memorandum and Certifications | Travis Gray | 07/29/2013 | 07/29/2013 |

**SERFF Tracking #:** MLCO-129025213 **State Tracking #:** 278052 **Company Tracking #:**

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

## Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Supporting Document | Unified Rate Review Template | Travis Gray | 07/29/2013 | 07/29/2013 |
| Supporting Document | Rate Sample | Travis Gray | 07/29/2013 | 07/29/2013 |

## Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| objection 1 | Note To Filer | Cathy Gilliland | 05/17/2013 | 05/17/2013 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

## Disposition

Disposition Date: 08/01/2013
Implementation Date: 01/01/2014
Status: Filed

HHS Status: HHS Approved
State Review: Reviewed by Actuary

Comment: State Tracking #278052
Company: Colorado Choice HP
Product Line: Individual HMO Rate Change Summary

Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014

This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing. The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).

Both On and Off Exchange Plans
Gold: 3 plans
Silver: 5 plans
Bronze: 3 plans
Catastrophic: 1 plan

See attached document for more information on this filing.

| Company Name: | Company Rate Change: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|---|---|---|---|---|---|---|---|---|
| Colorado Choice Health Plans | New Product | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | 0.000% |

***SERFF Tracking #:*** *MLCO-129025213* ***State Tracking #:*** *278052* ***Company Tracking #:***

***State:*** *Colorado* ***Filing Company:*** *Colorado Choice Health Plans*
***TOI/Sub-TOI:*** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
***Product Name:*** *Colorado Choice - Individual Market*
***Project Name/Number:*** */*

**Percent Change Approved:**
**Minimum:** 0.000%
**Maximum:** 0.000%
**Weighted Average:** 0.000%

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | HR-1 Form (H) | | Yes |
| **Supporting Document** | Consumer Disclosure Form | | Yes |
| **Supporting Document (revised)** | Actuarial Memorandum and Certifications | | Yes |
| **Supporting Document** | Actuarial Memorandum and Certifications | | Yes |
| **Supporting Document (revised)** | Unified Rate Review Template | | Yes |
| **Supporting Document** | Unified Rate Review Template | | Yes |
| **Supporting Document** | Letter of Authority | | Yes |
| **Supporting Document (revised)** | Rate Sample | | Yes |
| **Supporting Document** | Rate Sample | | Yes |
| **Supporting Document** | Response to 2013-05-21 Objections Letter | | Yes |
| **Supporting Document** | Response to 2013-05-27 Objections Letter | | Yes |
| **Supporting Document** | Response to 2103-06-05 Objections Letter | | Yes |
| **Supporting Document** | Response to 2013-06-14 Objections Letter | | Yes |
| **Form** | ValueChoice 100 - SBC | | Yes |
| **Form** | SBC BronzeChoice HSA 3000/50 - SBC | | Yes |
| **Form** | SBC BronzeChoice 3000/50 - SBC | | Yes |
| **Form** | SBC BronzeChoice 5000/50 - SBC | | Yes |
| **Form** | SBC SilverChoice HSA 1500/30 - SBC | | Yes |
| **Form** | SBC SilverChoice 1500/50 - SBC | | Yes |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Form** | SBC SilverChoice 2000/40 - SBC | | Yes |
| **Form** | SBC SilverChoice 2000/50 - SBC | | Yes |
| **Form** | SBC SilverChoice 3000/30 - SBC | | Yes |
| **Form** | SBC GoldChoice 500/30 - SBC | | Yes |
| **Form** | SBC GoldChoice 1000/20 - SBC | | Yes |
| **Form** | SBC GoldChoice 1500/20 - SBC | | Yes |
| **Form** | Individual Evidence of Coverage | | Yes |
| **Form** | Individual Product Application | | Yes |
| **Rate (revised)** | Rating Manual - CCHP Individual Market (Updated 7-29) | | Yes |
| **Rate** | Rating Manual - CCHP Individual Market | | Yes |

Final Disposition Letter

State Tracking #278052
Company: Colorado Choice HP
Product Line: Individual HMO

**Rate Change Summary**

Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).

Both On and Off Exchange Plans
Gold: 3 plans
Silver: 5 plans
Bronze: 3 plans
Catastrophic: 1 plan

**Rate Methodology**

Experience Used for Rate Setting: 'Milliman HCG data is used since CO Choice has no Non-GF Individual experience to use.

2012 Experience Period Loss Ratio: None

Annual Health Cost Trends: 8.1%.

Risk Adjustment: -12.58% (payments expected from the federal Risk Adjustment Program in 2014).

Reinsurance Recoveries: -14.0% (payments expected from the federal Reinsurance Program in 2014).

Smoking Factor: 15% higher rates for smokers at all ages.

Age Rating: 3.0 to 1.0 age rating factor limits for all adults age 21 and over.

Colorado 2014 Overall Average Premium: $308.07

* Federal Reported 2014 Comparable Average Premium: $308.07

* This is reported on the issuer's CMS URRT Form submitted in HIOS. It represents a standardized average premium calculation that is used by CMS for comparing and gauging premium development. It is not necessarily the actual average premium, which is shown in the line above as Colorado 2014 Overall Average Premium.

**Premium Retained to Cover Expenses, Taxes Fees and Profits**

Administrative costs: Expenses the insurance company pays to operate this insurance plan.

This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the company's offices and equipment, commissions to agents to sell and service policies, subsidies to cover legally required plans such as portability, and taxes.

Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company.

Average premium retention is 24.69% shown as follows:

| | | % of Premium Retained |
|---|---|---|
| | **Issuer Primary Expense and Profit Retention** | |
| | Administrative Expenses: | 15.00% |
| | Commissions: | 1.50% |
| | Profit and Contingencies: | 3.00% |
| | Investment Income: | 0.00% |
| (A) | Total: | 19.50% |
| | **Retention for Additional Required Taxes, Fees and Assessments** | |
| | PPACA Health Insurer Fee: | 0.00% |
| | PPACA Reinsurance Fee: | 1.70% |
| | PPACA CERF Fee: | 0.05% |
| | PPACA Risk Adjustment User Fee: | 0.03% |
| | PPACA PCORI Fee: | |
| | Exchange user fees: | 1.40% |
| | Premium Taxes: | |
| | State Income Taxes: | |
| | Other Fees, Assessments, Taxes: | |
| (B) | Total: | 3.18% |
| | **Additional Allowed for QI & Member Welfare Section** | |
| | Quality Improvement: | 2.01% |
| | Community Charitable: | |
| | IT for ICD-10 Conversion (max allowed 0.3%): | |
| (C) | Total: | 2.01% |
| (D) | Total Premium Retention For All Purposes (A + B + C): | 24.69% |
| (E) | Colorado Conventional Loss Ratio (100% - D): | 75.31% |
| | Federal MLR Loss Ratio Basis: (E + C) / (100% - B - FIT): | 79.86% |

**Sample of Final Premium Levels**

| | Denver | | | | Fort Collins | | | |
|---|---|---|---|---|---|---|---|---|
| | 21 Year Old | | 64 Year Old | | 21 Year Old | | 64 Year Old | |
| | Low | High | Low | High | Low | High | Low | High |
| Gold | $261.10 | $264.95 | $783.29 | $794.84 | $317.62 | $322.31 | $952.87 | $966.92 |
| Silver | $230.39 | $237.69 | $691.16 | $713.06 | $280.26 | $289.14 | $840.79 | $867.43 |
| Bronze | $180.32 | $183.90 | $540.95 | $551.69 | $219.35 | $223.71 | $658.06 | $671.12 |
| Catastrophic | $177.08 | $177.08 | $531.24 | $531.24 | $215.42 | $215.42 | $646.25 | $646.25 |

**Division Objections and Rate Changes During the Review Process**

The issuer was able to answer all questions from the Division and provided all required support.

**Final Rate Filing Disposition**

The Division has filed the rates in their final form after all adjustments.

**State:** *Colorado* **Filing Company:** *Colorado Choice Health Plans*
**TOI/Sub-TOI:** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
**Product Name:** *Colorado Choice - Individual Market*
**Project Name/Number:** */*

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 06/14/2013 |
| Submitted Date | 06/14/2013 |
| Respond By Date | 06/19/2013 |

*Dear Travis Gray,*

***Introduction:***

*This filing has been received, but before further action can be taken, please address the following:*

***Objection 1***

*Comments: Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.*

***Conclusion:***

*If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.*

*Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/19/2013, which is within 5 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/19/2013.*

*The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.*

*Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.*

*Sincerely,*

*Rachel Plummer*

**State:** *Colorado* **Filing Company:** *Colorado Choice Health Plans*
**TOI/Sub-TOI:** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
**Product Name:** *Colorado Choice - Individual Market*
**Project Name/Number:** */*

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 06/05/2013 |
| Submitted Date | 06/05/2013 |
| Respond By Date | 06/12/2013 |

*Dear Travis Gray,*

***Introduction:***

*This filing has been received, but before further action can be taken, please address the following:*

***Objection 1***

*Comments: objection 6 Regulation 4-2-11 section 6 (N) The experience needs to be provided on how the rates were developed. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided.*

***Conclusion:***

*.*

*Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/12/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/12/2013.*

*The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.*

*Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.*

*Sincerely,*

*Cathy Gilliland*

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 05/27/2013 |
| Submitted Date | 05/27/2013 |
| Respond By Date | 06/03/2013 |

*Dear Travis Gray,*

***Introduction:***

*This filing has been received, but before further action can be taken, please address the following:*

***Objection 1***

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: In the final disposition letter to consumers for this filing the Division proposes to illustrate premium retained to cover expenses, profit and fees in the following format:*

*General Administrative Expenses: 15.0%*
*Commissions: 1.5%*
*Profit and Contingencies: 3.0%*

*Retention for Admin, Commissions and Profit: 19.5%*

*Health Insurer Fees: 0.0%*
*Transitional Reinsurance program Fees: 1.7%*
*Federal CERF: 0.03%*
*Federal Risk Adj Fee: 0.05%*
*Colorado Exchange Fee: 1.4%*

*Premium Retained to Pay Taxes and Fees: 3.18%*

*Quality Improvement: 2.01%*

*Total Member Premium Retained for All Purposes: 24.7%*

*Colorado Loss Ratio: 75.3%*

*Projected 2014 Federal MLR = 80.2%*

*Please verify each retention item in the illustration above.*

*We would write your Table 2 in the Actuarial Memorandum as follows:*

*A. Expected Claims: $270.01*
*B. Transitional Reinsurance Claim Recoveries: -$38.00 ( Expected claims paid by the federal program )*

*C1. Colorado Exchange Fees: $4.31*
*C2. Transitional Reinsurance Program Fees: $5.25*

*C3. Health Insurer Fees: $0.00*
*C4. CERF Fee: $0.09*
*C5. Risk Adjustment Fee: $0.15*
*C6. Administrative Expenses: $46.21*
*C7. Commissions: $4.62*
*C8. Quality Improvement Expenses: $6.19*

*D. Profit and Contingencies: $9.24*

*E. Total Required premium: $308.07*

*Retention = ( C1 + C2 + C3 + C4 + C5 + C6 + C7 + C8 ) + D = $76.06*
*Retention % = $76.06 / $308.07 = 24.7%*
*Loss ratio = 1 - Retention = 75.3% = $232.01 / $308.07 = expected losses / expected premium , which is the definition of anticipated loss ratio in the alignment bill.*

***Objection 2***

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: The PPACA final Market Rule defines Plan Level Adjustments to be the following specific rating adjustments (45 CFR Part 156.80(d)2):*

*"Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a*
*particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:*

*(i) The actuarial value and cost-sharing design of the plan.*
*(ii) The plans provider network, delivery system characteristics, and utilization management practices.*
*(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations*
*for plans that offer those benefits in addition to essential health benefits.*
*(iv) Administrative costs, excluding Exchange user fees.*
*(v) With respect to catastrophic plans, the expected impact of the specific eligibility"*

*Please provide each of these specific Plan Level rating adjustments that you are applying for each plan in this rate filing, show how they roll up to your total Plan Rating Factor shown for each plan.*

***Conclusion:***

*If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.*

*Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/03/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/03/2013.*

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

*The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.*

*Failure to provide a full or complete response, or to request an extension for a specified period, will result in the rate filing being DISAPPROVED on the basis that the rate filing is incomplete, pursuant to §10-16-107(1.6)(a)(V), C.R.S. Proposed rates may not be used in any manner until an adequate response to this objection has been received and the above referenced rate filing has been approved by the Division.*

*Sincerely,*
*Michael Muldoon*

**State:** *Colorado* **Filing Company:** *Colorado Choice Health Plans*
**TOI/Sub-TOI:** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
**Product Name:** *Colorado Choice - Individual Market*
**Project Name/Number:** */*

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 05/21/2013 |
| Submitted Date | 05/21/2013 |
| Respond By Date | 06/04/2013 |

*Dear Travis Gray,*

***Introduction:***

*This filing has been received, but before further action can be taken, please address the following:*

***Objection 1***

*Comments: Please correct the requested filing mode to file and use*

***Objection 2***

*Comments: Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk.*

***Objection 3***

*Comments: Please provide all overall rate impact on the rate schedule tab for (0%)*

***Objection 4***

*Comments: Please provide the % amount on the rate rule schedule for (0%) Overall % Indicated Change: Overall % Rate Impact: Written Premium Change for this Program: # of Policy Holders Affected for this Program: Written Premium for this Program: Maximum % Change (where required): Minimum % Change (where required):*
*Colorado Choice Health Plans New Product % % % %*

***Objection 5***

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: Regulation 4-2-11 section 6 (E) Please indicate which of the following PPACA benefits your plan has implemented:*
*Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA*
*Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA*
*Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA*
*Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA*
*Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA*
*Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA*
*Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA*
*Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA*
*Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA*
*Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA*

***Objection 6***

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.*
*1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.*
*2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any*

*rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.*

*3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available.*

*4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience.*

*a. For Renewal filings the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.*

*b. For new business filings the experience period must include consecutive data no older than nine months prior to the effective implementation date.*

*The loss data must be on an incurred basis, including both separately and combined accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information about how the number of claims was calculated.*

*When a carrier files a new policy form, they need to submit support for the new policy form. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy form.*

*O. Side-by-Side Comparison: Each memorandum must include a side-by-side comparison*

***Objection 7***

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: This should be annual and should match the requested Premium and claims on the view rate review detail. The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.*

***Objection 8***

*Comments: Please explain why your annual financials for your retention components for General expenses, commissions are different*

***Conclusion:***

*.*

*Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/04/2013, which is within 14 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/04/2013.*

*The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.*

*Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.*

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

*Sincerely,*
*Cathy Gilliland*

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 05/15/2013 |
| Submitted Date | 05/15/2013 |
| Respond By Date | 05/22/2013 |

*Dear Travis Gray,*

***Introduction:***

*This filing has been received, but before further action can be taken, please address the following:*

***Objection 1***

*Comments: Please provide the Individual Actuarial Memoorandum in a XLS document. We are not able to populate the xlsx docs.*

***Conclusion:***

*Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 05/22/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 05/22/2013.*

*The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.*

*Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.*

*Sincerely,*

*Cathy Gilliland*

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 06/19/2013 |
| Submitted Date | 06/19/2013 |

*Dear Cathy Gilliland,*

***Introduction:***

*Please see the attached for our response to this objection.*

***Response 1***

***Comments:***

*As requested, we have included both a PDF and an Excel version of our response.*

***Related Objection 1***

*Comments: Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.*

***Changed Items:***

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Response to 2013-06-14 Objections Letter |
| **Comments:** | As requested, we have included both a PDF and an Excel version of our response to this objection. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-06-14 Objections Letter.pdf<br>COH - Individual Objection Response 06-14-2013.xlsx |

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Conclusion:***

*Sincerely,*
*Travis Gray*

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 06/11/2013 |
| Submitted Date | 06/11/2013 |

*Dear Cathy Gilliland,*

***Introduction:***

*Please see the attached document for our response to this objection.*

***Response 1***

***Comments:***

*Please see the attached document for our response to this objection.*

***Related Objection 1***

*Comments: objection 6 Regulation 4-2-11 section 6 (N) The experience needs to be provided on how the rates were developed. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided.*

***Changed Items:***

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Response to 2103-06-05 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-06-05. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-06-05 Objections Letter.pdf |

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Conclusion:***

*Sincerely,*
*Travis Gray*

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 06/03/2013 |
| Submitted Date | 06/03/2013 |

*Dear Cathy Gilliland,*

***Introduction:***

*Please find our responses to the listed objections in the attached PDF document.*

***Response 1***

***Comments:***

*Please find our responses to the listed objections in the attached PDF document.*

***Related Objection 1***

*Applies To:*

- *Actuarial Memorandum and Certifications (Supporting Document)*

| | | | | | |
|---|---|---|---|---|---|
| **SERFF Tracking #:** | MLCO-129025213 | **State Tracking #:** | 278052 | **Company Tracking #:** | |

| | | | |
|---|---|---|---|
| **State:** | Colorado | **Filing Company:** | Colorado Choice Health Plans |
| **TOI/Sub-TOI:** | HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO | | |
| **Product Name:** | Colorado Choice - Individual Market | | |
| **Project Name/Number:** | / | | |

*Comments: In the final disposition letter to consumers for this filing the Division proposes to illustrate premium retained to cover expenses, profit and fees in the following format:*

*General Administrative Expenses: 15.0%*
*Commissions: 1.5%*
*Profit and Contingencies: 3.0%*

*Retention for Admin, Commissions and Profit: 19.5%*

*Health Insurer Fees: 0.0%*
*Transitional Reinsurance program Fees: 1.7%*
*Federal CERF: 0.03%*
*Federal Risk Adj Fee: 0.05%*
*Colorado Exchange Fee: 1.4%*

*Premium Retained to Pay Taxes and Fees: 3.18%*

*Quality Improvement: 2.01%*

*Total Member Premium Retained for All Purposes: 24.7%*

*Colorado Loss Ratio: 75.3%*

*Projected 2014 Federal MLR = 80.2%*

*Please verify each retention item in the illustration above.*

*We would write your Table 2 in the Actuarial Memorandum as follows:*

*A. Expected Claims: $270.01*
*B. Transitional Reinsurance Claim Recoveries: -$38.00 ( Expected claims paid by the federal program )*

*C1. Colorado Exchange Fees: $4.31*
*C2. Transitional Reinsurance Program Fees: $5.25*
*C3. Health Insurer Fees: $0.00*

*C4. CERF Fee: $0.09*
*C5. Risk Adjustment Fee: $0.15*
*C6. Administrative Expenses: $46.21*
*C7. Commissions: $4.62*
*C8. Quality Improvement Expenses: $6.19*

*D. Profit and Contingencies: $9.24*

*E. Total Required premium: $308.07*

*Retention = ( C1 + C2 + C3 + C4 + C5 + C6 + C7 + C8 ) + D = $76.06*
*Retention % = $76.06 / $308.07 = 24.7%*
*Loss ratio = 1 - Retention = 75.3% = $232.01 / $308.07 = expected losses / expected premium , which is the definition of anticipated loss ratio in the alignment bill.*

***Changed Items:***

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Response to 2013-05-27 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-05-27. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-05-27 Objections Letter.pdf |

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Response 2***

***Comments:***

*Please find our responses to the listed objections in the attached PDF document.*

***Related Objection 2***

*Applies To:*

- *Actuarial Memorandum and Certifications (Supporting Document)*

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

*Comments: The PPACA final Market Rule defines Plan Level Adjustments to be the following specific rating adjustments (45 CFR Part 156.80(d)2):*

*"Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:*

*(i) The actuarial value and cost-sharing design of the plan.*
*(ii) The plans provider network, delivery system characteristics, and utilization management practices.*
*(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations*
*for plans that offer those benefits in addition to essential health benefits.*
*(iv) Administrative costs, excluding Exchange user fees.*
*(v) With respect to catastrophic plans, the expected impact of the specific eligibility"*

*Please provide each of these specific Plan Level rating adjustments that you are applying for each plan in this rate filing, show how they roll up to your total Plan Rating Factor shown for each plan.*

***Changed Items:***

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Response to 2013-05-27 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-05-27. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-05-27 Objections Letter.pdf |

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Conclusion:***

*Sincerely,*
*Travis Gray*

| | | | | | |
|---|---|---|---|---|---|
| **SERFF Tracking #:** | MLCO-129025213 | **State Tracking #:** | 278052 | **Company Tracking #:** | |

| | | | |
|---|---|---|---|
| **State:** | Colorado | **Filing Company:** | Colorado Choice Health Plans |
| **TOI/Sub-TOI:** | HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO | | |
| **Product Name:** | Colorado Choice - Individual Market | | |
| **Project Name/Number:** | / | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 06/03/2013 |
| Submitted Date | 06/03/2013 |

*Dear Cathy Gilliland,*

***Introduction:***

*We have included a pdf file that contains our responses to the objections in this letter.*

***Response 1***

***Comments:***

*We have updated this field in SERFF in a "Post Submission Update" dated June 3.*

***Related Objection 1***

*Comments: Please correct the requested filing mode to file and use*

***Changed Items:***

*No Supporting Documents changed.*

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Response 2***

***Comments:***

*Thank you for this information.*

***Related Objection 2***

*Comments: Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk.*

***Changed Items:***

*No Supporting Documents changed.*

*No Form Schedule items changed.*

No Rate/Rule Schedule items changed.

### Response 3

#### Comments:

We have edited this information in SERFF. It now says 0% in this cell (these are new products without any existing rates against which the proposed rates can be compared).

### Related Objection 3

Comments: Please provide all overall rate impact on the rate schedule tab for (0%)

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### Response 4

#### Comments:

We have edited this information in SERFF. It now says 0% in all these cells (these are new products without any existing rates against which the proposed rates can be compared).

### Related Objection 4

Comments: Please provide the % amount on the rate rule schedule for (0%) Overall % Indicated Change: Overall % Rate Impact: Written Premium Change for this Program: # of Policy Holders Affected for this Program: Written Premium for this Program: Maximum % Change (where required): Minimum % Change (where required): Colorado Choice Health Plans New Product % % % %

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### Response 5

#### Comments:

We have implemented each of the benefits listed. Please see the attached objections response letter for more details.

***Related Objection 5***

*Applies To:*

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: Regulation 4-2-11 section 6 (E) Please indicate which of the following PPACA benefits your plan has implemented:*
*Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA*
*Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA*
*Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA*
*Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA*
*Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA*
*Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA*
*Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA*
*Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA*
*Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA*
*Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA*

***Changed Items:***

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Response to 2013-05-21 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-05-21. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-05-21 Objections Letter.pdf |

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Response 6***

***Comments:***

*These are new products without any prior experience, consistent with our response in Section L of the actuarial memorandum. Section K of the actuarial memorandum provides a detailed description of the process by which the proposed rates were developed.*

*Because these are new products, a side-by-side comparison would not have anything comparable for the experience period.*

***Related Objection 6***

*Applies To:*

- Actuarial Memorandum and Certifications (Supporting Document)

Comments: Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.
1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.
3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available.
4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience.
a. For Renewal filings the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.
b. For new business filings the experience period must include consecutive data no older than nine months prior to the effective implementation date.
The loss data must be on an incurred basis, including both separately and combined accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information about how the number of claims was calculated.
When a carrier files a new policy form, they need to submit support for the new policy form. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy form.
O. Side-by-Side Comparison: Each memorandum must include a side-by-side comparison

***Changed Items:***

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

***Response 7***

***Comments:***

We have included a tabular version of the data entered on the requested rate section in SERFF in the attached objections response letter.

Note that the rate review detail for projected incurred claims does not include risk adjuster receipts, while the benefit ratio calculation in the actuarial memorandum, Section P, does incorporate risk adjuster receipts as an offset to claims. This is the reason that the ratio in the aforementioned table is not the same as the original table in Section P of the memorandum.

***Related Objection 7***

*Applies To:*

*- Actuarial Memorandum and Certifications (Supporting Document)*

*Comments: Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: This should be annual and should match the requested Premium and claims on the view rate review detail. The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.*

***Changed Items:***

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Response to 2013-05-21 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-05-21. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-05-21 Objections Letter.pdf |

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Response 8***

***Comments:***

*These are new products, and therefore, previous expense allocations are not appropriate. Specifically, Colorado Choice has limited experience with individual market products in the past. Additionally, the large change in the market landscape due to the PPACA introduces additional requirements and fees. We have developed new projections for retention components that we believe are more appropriate.*

*Therefore, the retention components in our annual statements are not intended to be replicated for these future products.*

***Related Objection 8***

*Comments: Please explain why your annual financials for your retention components for General expenses, commissions are different*

***Changed Items:***

*No Supporting Documents changed.*

*No Form Schedule items changed.*

| | | | | | |
|---|---|---|---|---|---|
| **SERFF Tracking #:** | MLCO-129025213 | **State Tracking #:** | 278052 | **Company Tracking #:** | |

| | | | |
|---|---|---|---|
| **State:** | Colorado | **Filing Company:** | Colorado Choice Health Plans |
| **TOI/Sub-TOI:** | HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO | | |
| **Product Name:** | Colorado Choice - Individual Market | | |
| **Project Name/Number:** | / | | |

No Rate/Rule Schedule items changed.

**Conclusion:**

Sincerely,
Travis Gray

**State:** *Colorado* **Filing Company:** *Colorado Choice Health Plans*
**TOI/Sub-TOI:** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
**Product Name:** *Colorado Choice - Individual Market*
**Project Name/Number:** */*

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 06/11/2013 |
| Submitted Date | 06/11/2013 |

*Dear Cathy Gilliland,*

***Introduction:***

***Response 1***

***Comments:***

*Per your 5/17 comment, this objection was already handled.*

***Related Objection 1***

*Comments: Please provide the Individual Actuarial Memoorandum in a XLS document. We are not able to populate the xlsx docs.*

***Changed Items:***

*No Supporting Documents changed.*

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Conclusion:***

*Sincerely,*
*Travis Gray*

| | | | | |
|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

# Amendment Letter

Submitted Date: 07/29/2013

Comments:

This amendment includes updates necessary due to member coinsurance changes for three plans as mandated by the DOI.

We were not allowed by SERFF to update the "Rate Review Detail" information that would be modified as a result of these changes.

Changed Items:

*No Form Schedule Items Changed.*

| **Rate/Rule Schedule Item Changes** | | | | | | |
|---|---|---|---|---|---|---|
| **Item No.** | **Document Name** | **Affected Form Numbers (Separated with commas)** | **Rate Action** | **Rate Action Information** | **Attachments** | **Date Submitted** |
| 1 | Rating Manual - CCHP Individual Market (Updated 7-29) | | New | | Rating Manual - CCHP Individual Mkt Plans.pdf, | 07/29/2013 By: |
| *Previous Version* | | | | | | |
| *1* | *Rating Manual - CCHP Individual Market* | | *New* | | *Rating Manual - CCHP Individual Market Plans.pdf,* | *05/15/2013 By: Travis Gray* |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

| **Supporting Document Schedule Item Changes** | |
|---|---|
| **Satisfied - Item:** | Actuarial Memorandum and Certifications |
| **Comments:** | Includes the following for individual market products (Updated 7/29):<br><br>Part III Memorandum<br>Actuarial Certification & Colorado Actuarial Memorandum (combined)<br>Excel template |
| **Attachment(s):** | Milliman - CCHP Part III memorandum - Individual.pdf<br>Milliman - Actuarial memorandum - CCHP Individual Products.pdf<br>Individual Actuarial Memorandum Template 7-26-2013.xlsx |
| *Previous Version* | |
| **Satisfied - Item:** | *Actuarial Memorandum and Certifications* |
| **Comments:** | *Includes the following for individual market products:*<br><br>*Part III Memorandum*<br>*Actuarial Certification*<br>*Colorado Actuarial Memorandum*<br>*Excel template* |
| **Attachment(s):** | *Milliman - Actuarial Certification - CCHP Individual Products 2013-05-14.pdf*<br>*Milliman - Actuarial memorandum - CCHP Individual Products 2013-05-14.pdf*<br>*Milliman - CCHP Part III memorandum - Individual 2013-05-14.pdf*<br>*Individual Actuarial Memorandum Template (populated) 5-14-2013.xlsx* |

| | |
|---|---|
| **Satisfied - Item:** | Unified Rate Review Template |
| **Comments:** | This is the URRT for CCHP individual market products. We have attached both the Excel and XML versions. Updated 7/29. |
| **Attachment(s):** | CCHPIndividualUnifiedRateReviewSubmission2013-07-29_20130729161040.xml<br>CCHP - Individual URRT 7-26-2013.xlsm |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

| | |
|---|---|
| *Previous Version* | |
| **Satisfied - Item:** | *Unified Rate Review Template* |
| **Comments:** | *This is the URRT for CCHP individual market products. We have attached both the Excel and XML versions.* |
| **Attachment(s):** | *CCHP - Individual URRT 5-7-2013.xlsm* |

| | |
|---|---|
| **Satisfied - Item:** | Rate Sample |
| **Comments:** | As required by the state, this contains sample 40 year old, non-tobacco rates for the richest and leanest Gold and Silver Plans. Updated 7/29. |
| **Attachment(s):** | State of Colorado - Rate Sample Individual 7-26-2013.xlsx |
| *Previous Version* | |
| **Satisfied - Item:** | *Rate Sample* |
| **Comments:** | *As required by the state, this contains sample 40 year old, non-tobacco rates for the richest and leanest Gold and Silver Plans.* |
| **Attachment(s):** | *State of Colorado - Rate Sample Individual.xlsx* |

***State:*** *Colorado* ***Filing Company:*** *Colorado Choice Health Plans*
***TOI/Sub-TOI:*** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
***Product Name:*** *Colorado Choice - Individual Market*
***Project Name/Number:*** */*

# Note To Filer

**Created By:**

Cathy Gilliland on 05/17/2013 11:42 AM

**Last Edited By:**

Cathy Gilliland

**Submitted On:**

05/21/2013 08:59 AM

**Subject:**

objection 1

**Comments:**

please disregard objection 1 as we were able to open to file.

***State:*** *Colorado* ***Filing Company:*** *Colorado Choice Health Plans*
***TOI/Sub-TOI:*** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
***Product Name:*** *Colorado Choice - Individual Market*
***Project Name/Number:*** */*

# Post Submission Update Request Processed On 06/04/2013

| | |
|---|---|
| Status: | Allowed |
| Created By: | Travis Gray |
| Processed By: | Cathy Gilliland |
| Comments: | |

**General Information:**

| Field Name | Requested Change | Prior Value |
|---|---|---|
| Requested Filing Mode | File & Use | Review & Approval |

**Company Rate Information:**

Company Name:Colorado Choice Health Plans

| Field Name | Requested Change | Prior Value |
|---|---|---|
| Overall % Indicated Change | 0.000% | |
| Overall % Rate Impact | 0.000% | |
| Written Premium Change for this Program | $0 | |
| # of Policy Holders Affected for this Program | 0 | |
| Written Premium for this Program | $0 | |
| Maximum %Change (where required) | 0.000% | |
| Minimum %Change (where required) | 0.000% | |

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

## Form Schedule

**Lead Form Number:**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 1 | | ValueChoice 100 - SBC | 63312CO0600001 SBC2014 | POL | Initial | | | |
| 2 | | SBC BronzeChoice HSA 3000/50 - SBC | 63312CO0600002 SBC2014 | POL | Initial | | | |
| 3 | | SBC BronzeChoice 3000/50 - SBC | 63312CO0600003 SBC2014 | POL | Initial | | | |
| 4 | | SBC BronzeChoice 5000/50 - SBC | 63312CO0600004 SBC2014 | POL | Initial | | | |
| 5 | | SBC SilverChoice HSA 1500/30 - SBC | 63312CO0600005 SBC2014 | POL | Initial | | | |
| 6 | | SBC SilverChoice 1500/50 - SBC | 63312CO0600006 SBC2014 | POL | Initial | | | |
| 7 | | SBC SilverChoice 2000/40 - SBC | 63312CO0600007 SBC2014 | POL | Initial | | | |
| 8 | | SBC SilverChoice 2000/50 - SBC | 63312CO0600008 SBC2014 | POL | Initial | | | |

**SERFF Tracking #:** MLCO-129025213 **State Tracking #:** 278052 **Company Tracking #:**

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

**Lead Form Number:**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 9 | | SBC SilverChoice 3000/30 - SBC | 63312CO0600009 SBC2014 | POL | Initial | | | |
| 10 | | SBC GoldChoice 500/30 - SBC | 63312CO0600010 SBC2014 | POL | Initial | | | |
| 11 | | SBC GoldChoice 1000/20 - SBC | 63312CO0600011 SBC2014 | POL | Initial | | | |
| 12 | | SBC GoldChoice 1500/20 - SBC | 63312CO0600012 SBC2014 | POL | Initial | | | |
| 13 | | Individual Evidence of Coverage | 63312CO060 - EOC | CER | Initial | | | |
| 14 | | Individual Product Application | 63312CO060 - UnApp | AEF | Initial | | | |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

| | | | |
|---|---|---|---|
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

**State:** *Colorado* **Filing Company:** *Colorado Choice Health Plans*
**TOI/Sub-TOI:** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
**Product Name:** *Colorado Choice - Individual Market*
**Project Name/Number:** */*

# Rate Justification

Rate Methodology
Experience Used for Rate Setting: 'Milliman HCG data is used since CO Choice has no Non-GF Individual experience to use.

2012 Experience Period Loss Ratio: None
Annual Health Cost Trends: 8.1
Risk Adjustment: -12.58payments expected from the federal Risk Adjustment Program in 2014).

Reinsurance Recoveries: -14.0 (payments expected from the federal Reinsurance Program in 2014).
Smoking Factor: 15igher rates for smokers at all ages.
Age Rating: 3.0 to 1.0 age rating factor limits for all adults age 21 and over.
Colorado 2014 Overall Average Premium: $308.07
* Federal Reported 2014 Comparable Average Premium: $308.07
* This is reported on the issuerâ€™s CMS URRT Form submitted in HIOS. It represents a standardized average premium calculation that is used by CMS for comparing and gauging premium develpment. It is not necessarily the actual average premium, which is shown in the line above as Colorado 2014 Overall Average Premium.

Premium Retained to Cover Expenses, Taxes Fees and Profits

Administrative costs: Expenses the insurance company pays to operate this insurance plan.
This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the companyâ€™s offices and equipment, commissions
to agents to sell and service policies, subsidies to cover legally required plans such as portability, and taxes.

Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company.

Average premium retention is 24.69hown as follows:
f Premium
Issuer Primary Expense and Profit Retention Retained
Administrative Expenses: 15.00 Commissions: 1.50 Profit and Contingencies: 3.00 Investment Income: 0.00A) Total: 19.50
Retention for Additional Required Taxes, Fees and Assessments
PPACA Health Insurer Fee: 0.00 PPACA Reinsurance Fee: 1.70 PPACA CERF Fee: 0.05 PPACA Risk Adjustment User Fee: 0.03 PPACA PCORI Fee:
Exchange user fees: 1.40 Premium Taxes:
State Income Taxes:
Other Fees, Assessments, Taxes:
(B) Total: 3.18
Additional Allowed for QI

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

# Rate Information

Rate data applies to filing.

| | |
|---|---|
| **Filing Method:** | Electronic |
| **Rate Change Type:** | % |
| **Overall Percentage of Last Rate Revision:** | % |
| **Effective Date of Last Rate Revision:** | |
| **Filing Method of Last Filing:** | |

## Company Rate Information

| Company Name: | Company Rate Change: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|---|---|---|---|---|---|---|---|---|
| Colorado Choice Health Plans | New Product | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | 0.000% |

| Product Type: | HMO | PPO | EPO | POS | HSA | HDHP | FFS | Other |
|---|---|---|---|---|---|---|---|---|
| Covered Lives: | | | | | | | | |
| Policy Holders: | | | | | | | | |

***State:*** *Colorado* ***Filing Company:*** *Colorado Choice Health Plans*
***TOI/Sub-TOI:*** *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
***Product Name:*** *Colorado Choice - Individual Market*
***Project Name/Number:*** */*

# Rate Review Detail

## COMPANY:

Company Name: Colorado Choice Health Plans
HHS Issuer Id: 63312
Product Names: ValueChoice 100, BronzeChoice HSA 3000/50, BronzeChoice 3000/50, BronzeChoice 5000/50, SilverChoice HSA 1500/30, SilverChoice 1500/50, SilverChoice 2000/40, SilverChoice 2000/50, SilverChoice 3000/30, GoldChoice 500/30, GoldChoice 1000/20, GoldChoice 1500/20
Trend Factors:

## FORMS:

New Policy Forms: 63312CO0600001 SBC2014, 63312CO0600002 SBC2014, 63312CO0600003 SBC2014, 63312CO0600004 SBC2014, 63312CO0600005 SBC2014, 63312CO0600006 SBC2014, 63312CO0600007 SBC2014, 63312CO0600008 SBC2014, 63312CO0600009 SBC2014, 63312CO0600010 SBC2014, 63312CO0600011 SBC2014, 63312CO0600012 SBC2014, 63312CO060 - EOC, 63312CO060 - UnApp,
Affected Forms:
Other Affected Forms:

## REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 160,761
Benefit Change:
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

## PRIOR RATE:

Total Earned Premium: 0.00
Total Incurred Claims: 0.00
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

## REQUESTED RATE:

Projected Earned Premium: 49,526,255.00
Projected Incurred Claims: 49,654,512.00
Annual $: Min: 100.63 Max: 1,128.32 Avg: 308.07

| | | | | |
|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

## Rate/Rule Schedule

| Item No. | Schedule Item Status | Document Name | Affected Form Numbers (Separated with commas) | Rate Action | Rate Action Information | Attachments |
|---|---|---|---|---|---|---|
| 1 | | Rating Manual - CCHP Individual Market (Updated 7-29) | | New | | Rating Manual - CCHP Individual Mkt Plans.pdf, |

# Colorado Choice Health Plans
## Individual Rating Manual

**Base Rate** 245.04

| Plan | Rate Factor |
|---|---|
| GoldChoice 1000/20 | 1.1145 |
| GoldChoice 1500/20 | 1.0985 |
| GoldChoice 500/30 | 1.1147 |
| SilverChoice 1750/40 | 1.0000 |
| SilverChoice 2000/40 | 0.9906 |
| SilverChoice HSA 1500/30 | 0.9693 |
| SilverChoice 2000/Copay | 0.9806 |
| SilverChoice 3000/30 | 0.9818 |
| BronzeChoice 5000/50 | 0.7586 |
| BronzeChoice 3000/50 | 0.7737 |
| BronzeChoice HSA 3000/50 | 0.7634 |
| ValueChoice 100 | 0.7450 |

**Tobacco Factors**

| Age Band | Rate Factor |
|---|---|
| 0-20 | 1.150 |
| 21-24 | 1.150 |
| 25-29 | 1.150 |
| 30-34 | 1.150 |
| 35-39 | 1.150 |
| 40-44 | 1.150 |
| 45-49 | 1.150 |
| 50-54 | 1.150 |
| 55-59 | 1.150 |
| 60-63 | 1.150 |
| 64+ | 1.150 |

**Geographic Factors**

| Area | Rate Factor |
|---|---|
| Rating Area 2 | 0.870 |
| Rating Area 3 | 0.970 |
| Rating Area 4 | 1.180 |
| Rating Area 6 | 1.200 |
| Rating Area 8 | 1.000 |
| Rating Area 9 | 1.180 |

| Age Band | Rate Factor |
|---|---|
| 0-20 | 0.635 |
| 21 | 1.000 |
| 22 | 1.000 |
| 23 | 1.000 |
| 24 | 1.000 |
| 25 | 1.004 |
| 26 | 1.024 |
| 27 | 1.048 |
| 28 | 1.087 |
| 29 | 1.119 |
| 30 | 1.135 |
| 31 | 1.159 |
| 32 | 1.183 |
| 33 | 1.198 |
| 34 | 1.214 |
| 35 | 1.222 |
| 36 | 1.230 |
| 37 | 1.238 |
| 38 | 1.246 |
| 39 | 1.262 |
| 40 | 1.278 |
| 41 | 1.302 |
| 42 | 1.325 |
| 43 | 1.357 |
| 44 | 1.397 |
| 45 | 1.444 |
| 46 | 1.500 |
| 47 | 1.563 |
| 48 | 1.635 |
| 49 | 1.706 |
| 50 | 1.786 |
| 51 | 1.865 |
| 52 | 1.952 |
| 53 | 2.040 |
| 54 | 2.135 |
| 55 | 2.230 |
| 56 | 2.333 |
| 57 | 2.437 |
| 58 | 2.548 |
| 59 | 2.603 |
| 60 | 2.714 |
| 61 | 2.810 |
| 62 | 2.873 |
| 63 | 2.952 |
| 64+ | 3.000 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

## Supporting Document Schedules

| | |
|---|---|
| **Bypassed - Item:** | HR-1 Form (H) |
| **Bypass Reason:** | No t required for ACA filings |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Consumer Disclosure Form |
| **Bypass Reason:** | Not needed for new filings |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Actuarial Memorandum and Certifications |
| **Comments:** | Includes the following for individual market products (Updated 7/29):<br><br>Part III Memorandum<br>Actuarial Certification & Colorado Actuarial Memorandum (combined)<br>Excel template |
| **Attachment(s):** | Milliman - CCHP Part III memorandum - Individual.pdf<br>Milliman - Actuarial memorandum - CCHP Individual Products.pdf<br>Individual Actuarial Memorandum Template 7-26-2013.xlsx |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Unified Rate Review Template |
| **Comments:** | This is the URRT for CCHP individual market products. We have attached both the Excel and XML versions. Updated 7/29. |
| **Attachment(s):** | CCHPIndividualUnifiedRateReviewSubmission2013-07-29_20130729161040.xml<br>CCHP - Individual URRT 7-26-2013.xlsm |
| **Item Status:** | |

| | |
|---|---|
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Letter of Authority |
| **Comments:** | This allows Milliman to submit these filings on behalf of Colorado Choice Health Plans |
| **Attachment(s):** | SERFF HIOS Permission Letter SIGNED.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Rate Sample |
| **Comments:** | As required by the state, this contains sample 40 year old, non-tobacco rates for the richest and leanest Gold and Silver Plans. Updated 7/29. |
| **Attachment(s):** | State of Colorado - Rate Sample Individual 7-26-2013.xlsx |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Response to 2013-05-21 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-05-21. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-05-21 Objections Letter.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Response to 2013-05-27 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-05-27. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-05-27 Objections Letter.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Response to 2103-06-05 Objections Letter |
| **Comments:** | This document contains our response to the objections letter dated 2013-06-05. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-06-05 Objections Letter.pdf |
| **Item Status:** | |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *MLCO-129025213* | ***State Tracking #:*** | *278052* | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Colorado* | ***Filing Company:*** | *Colorado Choice Health Plans* |
| ***TOI/Sub-TOI:*** | *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO* | | |
| ***Product Name:*** | *Colorado Choice - Individual Market* | | |
| ***Project Name/Number:*** | */* | | |

| | |
|---|---|
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Response to 2013-06-14 Objections Letter |
| **Comments:** | As requested, we have included both a PDF and an Excel version of our response to this objection. |
| **Attachment(s):** | CCHP Individual Market - Response to 2013-06-14 Objections Letter.pdf<br>COH - Individual Objection Response 06-14-2013.xlsx |
| **Item Status:** | |
| **Status Date:** | |

**State:** Colorado **Filing Company:** Colorado Choice Health Plans
**TOI/Sub-TOI:** HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
**Product Name:** Colorado Choice - Individual Market
**Project Name/Number:** /

***Attachment Individual Actuarial Memorandum Template 7-26-2013.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment CCHPIndividualUnifiedRateReviewSubmission2013-07-29_20130729161040.xml is not a PDF document and cannot be reproduced here.***

***Attachment CCHP - Individual URRT 7-26-2013.xlsm is not a PDF document and cannot be reproduced here.***

***Attachment State of Colorado - Rate Sample Individual 7-26-2013.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment COH - Individual Objection Response 06-14-2013.xlsx is not a PDF document and cannot be reproduced here.***

# Colorado Choice Health Plans
# Individual Comprehensive Medical Business
# Rate Filing Justification
# Part III - Actuarial Memorandum and Certification

## I. General Information

### *Company Identifying Information*

| | |
|---|---|
| Company Legal Name: | Colorado Choice Health Plans |
| State: | Colorado |
| HIOS Issuer ID: | 63312 |
| Market: | Individual |
| Effective Date: | January 1, 2014 |

### *Company Contact Information*

| | |
|---|---|
| Primary Contact Name: | Cynthia Palmer |
| Primary Contact Telephone Number: | (719) 589-3696 |
| Primary Contact Email-Address: | cpalmer@cochoice.com |

## II. Proposed Rate Increase(s)

This submission is for new products available for sale January 1, 2014. Colorado Choice Health Plans (CCHP) currently has no non-grandfathered policies, certificates, or covered lives on the individual market. Because these are new products, there are no proposed rate increases as there were no prior products against which to compare these rates.

Because no prior non-grandfathered claim experience was available for this product, the Milliman *Health Cost Guidelines*™ cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of CCHP's market given underwriting, rating, and benefit requirements effective January 1, 2014 under the Patient Protection and Affordable Care Act (ACA);
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

Each of these factors is discussed in more detail later in this memorandum.

## III. Experience Period Premium and Claims

### *Claims Paid Through Date*

CCHP does not have any prior non-grandfathered claim experience. Therefore, no paid claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

### *Premiums (net of MLR Rebate) in Experience Period*

CCHP has not collected any prior non-grandfathered premiums in this market. Therefore, no experience period premium information is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

### *Allowed and Incurred Claims Incurred During the Experience Period*

CCHP does not have any prior non-grandfathered claim experience. Therefore, no allowed and incurred claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period. Premiums were developed using a credibility manual rating approach.

## IV. Benefit Categories

CCHP does not have any prior non-grandfathered claim experience in the individual market. Therefore, no claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Because no prior non-grandfathered claim experience was available for this product, the Milliman *Health Cost Guidelines* (HCGs) cost and utilization information was used in the development of these rates.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Capitation *(which was not applicable in this context)*
- Prescription Drug

## V. Projection Factors

CCHP does not have any prior non-grandfathered claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates. This section describes the projection factors we used with the HCGs to develop the credibility manual rates for the projection period.

### *Projections and Adjustments Made to the Data*

Because the process for projecting and adjusting the data used to estimate the claim costs for these products involved a number of steps that are interrelated, the entire process is described here and will be used for reference throughout this document.

Claim costs for proposed plans were developed using the Milliman HCGs, with adjustments to reflect the relative value of CCHP's individual experience compared to the Milliman HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA.

We followed the steps below to adjust the Milliman *Health Cost Guidelines* claim experience to be on an appropriate basis for premiums for CCHP.

Step 1: Project Total Colorado Market Members and Health Status by Population Cohort

We expect significant shifts in the insured population when the health insurance Exchange opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.

- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Colorado.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual and SHOP Exchanges (i.e., "take up" rates). The Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an individual Exchange plan.

We then applied employer-sponsored insurance transition rates, small group, and individual / uninsured Exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For CCHP's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and Exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

Step 2: Project CCHP Enrollment by Market, Exchange Status, and Product

We projected CCHP's expected 2014 individual product enrollment on the exchange based on our estimate of the statewide population and CCHP's likely share of the total based on our assumed price relativity and appeal. We estimated the members that would select each of CCHP's benefit plans based on the plans for which they would qualify (given their age and income level) and assumed 8% of these members

are tobacco users. We also assumed that all 2014 members are enrolled for the entire year.

Step 3: Claim Cost Projection

The basis used to develop rates for these new products is the 2012 Milliman *Health Cost Guidelines*. The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado -specific unit cost and utilization basis.

Step 4: Adjustment for Changes in Morbidity

The data in the *Guidelines* is for a large group population. We believe this is a more appropriate basis for the development of future individual premium rates than current individual claim levels because large group experience includes a breadth of covered benefits consistent with those in the Essential Health Benefits (EHBs), and the impact of selection or medical underwriting present in the current individual market is mitigated by using non-underwritten large group experience. The *Guidelines* are based on the 2012 large group population. We project that the 2014 individual market population will have a different population profile than the current large group market, and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the large group claims to represent our estimate of the market average demographics and morbidity of the 2014 individual market.

As mentioned previously, through our population modeling we developed an estimate that the 2014 individual market will have a 12.2% higher morbidity than the current large group market, and so applied this adjustment factor to increase the claim costs.

***Changes in the Morbidity of the Population Insured***

We anticipate moderate changes in the average morbidity of this market in 2014 due to ACA provisions effective in January 2014. Please see Step 4 in the "Projections

and Adjustments Made to the Data" section above for a description of the development of the adjustment factor.

The projection factor of "Pop'l risk Morbidity" shown in Worksheet 1, Section II reflects the impact of the shift in mix over time. This projection factor was calculated based on our projection from the current credibility manual experience to the 2014 individual market morbidity. Note that this factor does not include the impact of changes in demographics to ensure that demographic shift is not counted twice.

***Changes in Benefits***

The underlying utilization and charge levels assumed in the 2012 Milliman *Health Cost Guidelines* baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out of pocket maximum. Adjustments were then made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been created by studying the historical impact of different contractual limitations and cost sharing on utilization experience by the covered population.

The adjustments we used to develop utilization rates consistent with these products are as follows:

- Starting with large group experience enables us to capture the impact of removal of underwriting and pre-existing condition exclusions in the current individual market, post 2014.
- Adjusted for the difference between the current large group and future (2014) individual market average risk status. This analysis involved a study of morbidity levels and relied on CPS data. The analysis is described in Step 4 of the following section.
- Adjusted for differences in benefit designs (e.g., metallic levels).
- Adjusted for changes from mandated benefits (e.g., EHBs)

***Changes in Demographics***

We expect significant shifts in the insured population when the health insurance Exchange opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market. Because we are using the HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 in the "Projections and Adjustments Made to the Data" section above for more details for these adjustments.

***Other Adjustments***

Because we are using the HCGs as the basis for these premiums, there are additional adjustments necessary to put the claim experience on a consistent basis

with these products. Please see Steps 1-4 in the “Projections and Adjustments Made to the Data” section for more details surrounding additional adjustments we made.

***Annualized Trend Factors***

The utilization and cost trend factors shown in Worksheet 1, Section II are reflective of an aggregate allowed charge trend of 8.1%. This aggregate value was developed based on the Milliman *Health Cost Guidelines* and general industry knowledge regarding recent trends in medical inflation.

Separate factors for utilization and cost were developed based on relative values from the Milliman *Health Cost Guidelines*. These factors result in an aggregate value of 8.1%.

These trend assumptions are based on the utilization and cost per service trends developed from claims data for the *Guidelines*. We have reviewed these trend assumptions and believe they are reasonable for this purpose. The trend assumptions above do not include the impact of changes in demographics, benefit design, or morbidity since those are captured elsewhere in the development of the index rate.

## VI. Credibility Manual Rate Development

CCHP does not have any prior non-grandfathered claim experience. Therefore, as mentioned previously, we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates.

***Source and Appropriateness of Experience Data Used***

The base experience for the proposed plans was composed of claim costs developed using the Milliman *Health Cost Guidelines*, chosen to reflect the demographic and unit cost differences specific to Colorado, as well as CCHP’s plan benefit designs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA. The *Health Cost Guidelines* are described in sections “IV Benefit Categories” and “Projections and Adjustments Made to the Data” above.

***Adjustments Made to the Data***

Adjustments made to the *Health Cost Guidelines* to create estimated claim costs for these products are described in detail in section “Projections and Adjustments Made to the Data” in Section 5 above.

***Inclusion of Capitation Payments***

The HCGs are based on nationwide claim experience, which include a complete picture for incurred and allowed dollars. These data include relevant capitation payments as part of the underlying claim experience. We anticipate that none of CCHP's medical (non-pharmacy) costs will be subject to a capitation arrangement.

***Portion of Cost Payable by HHS's Fund on Behalf of Insureds***

Because of the cost sharing reduction (CSR) provisions, HHS will pay a portion of these costs on behalf of members. We have estimated these costs based on our estimated enrollment of CSR eligible members. We have expressed this amount as a percentage of cost, in Worksheet 2. The amount of the subsidy was calculated by projecting enrollment in each CSR silver plan. As described above, we computed the projected allowed claim costs for each cohort of individual enrollees under the assumption that the benefit design was the standard (70% AV) silver plan. We increased this projected allowed amount for the impact of induced utilization, using the factors released by CMS for the purpose of applying the federal risk adjustment formula. Then, for each CSR plan, we computed the percentage point difference in actuarial value between the CSR plan and the standard silver plan (e.g., 24 points for the 94% plan, 17 points for the 87% plan, and 3 points for the 73% plan). The product of that difference and the projected allowed claim cost equals the amount of the subsidy provided by HHS.

## VII. Credibility of Experience

CCHP does not have any prior non-grandfathered claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for the Credibility Manual rates and have given them 100% credibility weight.

## VIII. Paid to Allowed Ratio

The Paid to Allowed ratio shown in Worksheet 1, Section II of the URRT was developed as our best estimate of the impact on cost sharing. We developed allowed claim costs, and used the Milliman HCGs to develop the expected portion of claims that are covered by the plan versus the member to develop the paid to allowed ratio. The paid to allowed ratio was developed as follows:

$$\frac{Weighted\ Average\ Paid\ Claim\ PMPM\ estimate}{Weighted\ Average\ Allowed\ Claim\ PMPM\ Estimate}$$

## IX. Risk Adjustment and Reinsurance

### *Projected Risk Adjustments PMPM*

CCHP recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, CCHP must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of CCHP's plans in this risk pool.

Since differences between CCHP's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must not be included in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which CCHP's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of CCHP's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at CCHP's expected morbidity level. The difference between the market average risk pool and CCHP's expected morbidity is our estimate of what the transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

*Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected statewide risk scores (to estimate CCHP's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age / gender claim cost factors from Milliman's *Health Cost Guidelines* to produce final statewide average risk scores for each population cohort.

*Project CCHP's Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected CCHP's risk scores (to estimate CCHP's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between CCHP and the overall Colorado market. Selection refers to the health status difference between a given

carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

*Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments*

We estimated statewide claim costs (to estimate the statewide premium in CCHP's risk adjustment transfer payment) by applying the steps above to estimate the PMPM claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. CCHP is not selling platinum products, but we did assume some percentage of take-up of those plans in the marketplace as a whole.

*Estimate CCHP's Risk Adjustment Transfer Payment*

We estimated CCHP's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, CCHP's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether CCHP receives or makes a transfer payment is how CCHP's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding CCHP's expenses to the statewide average claim costs described above. Next, we normalized CCHP's risk score to the statewide average risk score and removed the portion of CCHP's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received (or paid) by CCHP. As required, risk adjustment transfer revenue was allocated to plan premiums proportionally based on plan premium.

***Projected ACA Reinsurance Recoveries Net of Reinsurance***

Carriers pay contributions for the ACA reinsurance program, estimated to be $5.25 PMPM in 2014. Consistent with the Part III Actuarial Memorandum instructions, which state that this line item must be reported net of reinsurance contributions, we have included this payment on Worksheet 1, Section II of the URRT.

We assumed the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000. We estimated this value by calibrating the claims probability distributions (CPDs) from the HCGs for each of CCHP's individual benefit plans' estimated PMPM claims costs.

Projected PMPM ACA Reinsurance Recoveries in Worksheet 1, Section II of the URRT were calculated as follows:

- (Projected PMPM Incurred Claims before Risk Adjuster and Recoveries * 12. 2%) - $5.25

Projected allocations across plans are calculated as follows:

- Allocation % for Plan X =
  Projected Plan Premium before Reins / Total Plan Premium before Reins

- PMPM Allocation for Plan X = Total Recoveries * Allocation % for Plan X

## X. Non-Benefit Expenses and Profit & Risk

### *Administrative Expense Load*

Administrative expenses were developed on a PMPM basis using CCHP's projections for costs of operating its business in 2014, including the impact of general expense inflation. The value entered in Worksheet 1, Section II of the URRT illustrates this value as a percent of the index rate.

### *Profit & Risk Load*

Profit and Risk Load target values were determined as an aggregate value for the single-risk pool based on company targets and consideration for federal MLR requirements. The value entered in Worksheet 1, Section II of the URRT illustrates this value as a percent of the index rate.

***Taxes and Fees***

The table below provides a breakdown of projected taxes and fees illustrated in Worksheet 1, Section III of the URRT.

| Projected Taxes and Fees | | | |
|---|---|---|---|
| **Item** | **% Premium** | **PMPM** | **% of URRT Index Rate** |
| Premium Tax | 0.00% | $0.00 | 0.00% |
| Health Insurer Fee | 0.00% | $0.00 | 0.00% |
| Comparative Effectiveness Research | 0.05% | $0.17 | 0.04% |
| Risk Adjustment Admin Fee | 0.03% | $0.08 | 0.02% |
| Exchange User Fee | 1.40% | $4.35 | 0.97% |
| Total | 1.48% | $4.60 | 1.03% |

## XI. Projected Loss Ratio

The projected loss ratio based on the federally prescribed MLR methodology is 80.2 %. The numerator of the projected MLR contains projected claim costs and quality improvement expenses, net of receipts from the risk adjuster, reinsurance, and risk corridors programs. The denominator consists of total premiums, net of premium taxes and regulatory fees. A credibility adjustment is then applied to account for the small size of CCHP's projected enrollment. The following demonstrates our projection of CCHP's MLR, using the federal definition but not including any credibility adjustment (which could only increase the MLR):

$$80.2\% = \frac{\$311.39\ claims + \$6.23\ QI\ expense - \$39.17\ risk\ adjuster - \$32.79\ reinsurance}{\$310.88\ premium - \$4.60\ taxes\ \&\ fees}$$

## XII. Index Rate

As previously discussed, CCHP does not have prior non-grandfathered claim experience to use to develop an experience period index rate. We used a credibility manual approach, in which the base claims did not include cost for items which are not EHBs, and therefore did not need to be adjusted for the removal of non-EHBs.

The projected index rate includes the projected claim level for the projection period, including all adjustments for trend, benefit and demographic differences. It reflects the experience for all of the products we are developing since they are within a single risk pool. The projected index rate shown in Worksheet 1, Section II of the URRT was developed as follows:

Projected Allowed Claims PMPM × % of Allowed Claims Attributable to EHB

Projected allowed claims are those after credibility adjustments, but before any adjustment for risk adjuster or reinsurance payments and/or recoveries.

*Development of Plan Level Rates*

Plan level rates are developed based on the following approach:

Adjusted Index Rate =
- Index Rate
- +/- Risk Adjustment Payment
- +/- Reinsurance Recoveries net of Fees
- + User Exchange Fees

Plan Level Rate =
- Adjusted Index Rate
- × Plan actuarial value and cost sharing value factor
- × Administrative costs, excluding user exchange fees

There is no impact due to differences in provider networks, delivery system characteristics, or utilization management practices. All plans use the same network, delivery system, and utilization management practices.

## XIII. AV Metal Levels

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed based on the CMS Actuarial Value calculator.

We did not employ an alternate methodology to develop the AV Metal Values. For several CMS Actuarial Value Calculator inputs, it was necessary to use an alternate methodology to develop the AV Metal Value. The attached actuarial certification in Appendix B includes additional detail describing these calculations.

## XIV. AV Pricing Values

The fixed reference plan selected for purposes of developing AV Pricing Values is SilverChoice 1750/40.

Plan factors were derived based on the actuarial value of these products and the age/gender mix of the standard HCG population. Note that the Silver plans have relativities that are formed based on the expected mix of enrollment in the standard plans and their associated CSR plans (73% actuarial value, 87% actuarial value, and 94% actuarial value). Negligible enrollment is expected in the Native American plan variants. The plan factors below do not incorporate

differences in morbidity; overall morbidity is reflected in other rating factors and the index rate. Plan factors are presented in the table below:

| Product | Rate Factor | URRT AV Pricing Value |
|---|---|---|
| GoldChoice 1000/20 | 1.1145 | 1.087 |
| GoldChoice 1500/20 | 1.0985 | 1.070 |
| GoldChoice 500/30 | 1.1147 | 1.082 |
| SilverChoice 1750/40 | 1.0000 | 0.861 |
| SilverChoice 2000/40 | 0.9906 | 0.854 |
| SilverChoice HSA 1500/30 | 0.9693 | 0.822 |
| SilverChoice 2000/Copay | 0.9806 | 0.853 |
| SilverChoice 3000/30 | 0.9818 | 0.861 |
| BronzeChoice 5000/50 | 0.7586 | 0.710 |
| BronzeChoice 3000/50 | 0.7737 | 0.676 |
| BronzeChoice HSA 3000/50 | 0.7634 | 0.665 |
| ValueChoice 100 | 0.7450 | 0.301 |

Attachment A provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and the portion of the value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2).

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the Milliman *Health Cost Guidelines* to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

## XV. Membership Projections

Membership projections, as illustrated in Worksheet 2, Section IV of the URRT were developed by applying an assumed market penetration for CCHP to the total market size estimated as described above in Section V. Our assumed market penetration rate varies by income level.

We assume that the suite of silver and bronze products will be significantly more attractive than the gold product, and have accordingly assumed that 10% of CCHP enrollees will select gold plans, 50% of enrollees will select silver plans, and 40% of enrollees will select bronze plans. For each plan within a metal level, we assume that members will choose each of the plans at an equal proportion (for example, one-third of those choosing gold plans will choose each of the three gold plans offered).

If members were eligible for Cost Sharing Reduction plans, we assumed that they enrolled for the CSR plan for which they were eligible. For those who were eligible for the catastrophic plan due to age, we assume that 50% of those who would normally enroll in a bronze plan would enroll in the catastrophic plan.

## XVI. Terminated Products

CCHP intends to terminate all existing products in the individual market. All of these products are grandfathered plans.

## XVII. Plan Type

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT.

## XVIII. Warning Alerts

The following provides additional information regarding differences between the sum of the plan level experience and projections in Worksheet 2, Sections III and IV of the URRT and the total experience and projected amounts found on Worksheet 1 of the URRT:

1. A warning is found in cell A82. This appears to be due to a very minor Excel precision error, as the actual difference between the two cells being tested is $35 out of $49,977,923.
2. A warning is found in cell A99. We believe this is an error in the template's warning alert. The difference between the two cells being tested is $71.96, which is exactly the amount of CCHP's projected reinsurance and risk adjuster receipts. The instructions for this section state that the amounts entered in row 86 (Total Allowed Claims) "should be consistent with the total allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries entered in Section III of Worksheet 1." The test, however, compares this amount (net of reinsurance and risk adjustment) with an amount on Worksheet 1 that excludes reinsurance and risk adjustment.

## XIX. Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the management of CCHP. To the extent that it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum may be materially affected.

## XX. Actuarial Certification

I, Mary van der Heijde, am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of Colorado Choice Health Plans (the "Company").

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan specific premium rates. The allowable modifiers used to generate plan specific premium rates were based on the following:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the Essential Health Benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents Essential Health Benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.

I certify that the benefits included in CCHP's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Colorado benchmark plans.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Signed: 

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries

Dated: July 29, 2013

## Attachment A – AV Pricing Value Breakdown Summary

| Plan | AV Pricing Value | Adjust 1 AV/Cost Share | Adjust 2 Network | Adjust 3 Other Benefits | Adjust 4 Admin Expense | Adjust 5 Catastrophic | Total |
|---|---|---|---|---|---|---|---|
| GoldChoice 1000/20 | 1.1145 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| GoldChoice 1500/20 | 1.0985 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| GoldChoice 500/30 | 1.1147 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 1750/40 | 1.0000 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 2000/40 | 0.9906 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice HSA 1500/30 | 0.9693 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 2000/Copay | 0.9806 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 3000/30 | 0.9818 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice 5000/50 | 0.7586 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice 3000/50 | 0.7737 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice HSA 3000/50 | 0.7634 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| ValueChoice 100 | 0.7450 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |

# ACTUARIAL CERTIFICATION

## Colorado Choice Health Plans
## Individual Rate Filing Effective January 1, 2014
## GoldChoice 500/30, GoldChoice 1000/20, GoldChoice 1500/20, SilverChoice HSA 1500/30, SilverChoice 1750/40, SilverChoice 2000/40, SilverChoice 2000/Copay, SilverChoice 3000/30, BronzeChoice HSA 3000/50, BronzeChoice 3000/50, ValueChoice 100

I, Mary van der Heijde, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by Colorado Choice Health Plans (CCHP) to render this opinion. I meet the Academy qualification standards for rendering the opinion and am familiar with the applicable Colorado statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for individual rate filings. I am qualified to render this opinion under the qualifications set forth in Colorado Insurance Regulation 1-1-1.

In particular, this certification is being prepared to demonstrate compliance with Colorado Regulation 4-2-11, as promulgated under the authority of C.R.S. 10-1-109, 10-3-1110, 10-16-107, 10-16-109, and 10-18-105(2). It is not intended to be used for any other purpose.

### Actuarial Certification

To the best of my knowledge, this rate filing is in compliance with the applicable laws and regulations of the State of Colorado in effect as of July 29, 2013, except where those laws and regulations conflict with the Patient Protection and Affordable Care Act and its implementing regulations. In cases where Colorado law or regulation is in conflict with federal law or regulation, this rate filing complies with federal law or regulation or regulatory guidance. In my opinion, the premium rates described in my Actuarial Memorandum dated July 29, 2013, are not excessive, inadequate, or unfairly discriminatory.

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Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries
July 29, 2013

# ACTUARIAL MEMORANDUM

## Colorado Choice Health Plans
## Individual Rate Filing Effective January 1, 2014
## GoldChoice 500/30, GoldChoice 1000/20, GoldChoice 1500/20, SilverChoice HSA 1500/30, SilverChoice 1750/40, SilverChoice 2000/40, SilverChoice 2000/Copay, SilverChoice 3000/30, BronzeChoice HSA 3000/50, BronzeChoice 3000/50, ValueChoice 100

I, Mary van der Heijde, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by Colorado Choice Health Plans (CCHP) to prepare this memorandum. I meet the Academy qualification standards for rendering the opinion that accompanies this memorandum (dated July 29, 2013) and am familiar with the applicable Colorado statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for individual rate filings. I am qualified to render this opinion under the qualifications set forth in Colorado Insurance Regulation 1-1-1.

In particular, this memorandum is being prepared to demonstrate compliance with Colorado Regulation 4-2-11, as promulgated under the authority of C.R.S. 10-1-109, 10-3-1110, 10-16-107, 10-16-109, and 10-18-105(2). It is not intended to be used for any other purpose.

The Colorado Division of Insurance (DOI) released a document on May 7, 2013, entitled “PPACA Rate Filing Procedures for Colorado” (hereafter, “the May 7 guidance”). This document describes the desired content of the actuarial memorandum, and it differs in some ways from the instructions in Regulation 4-2-11 as currently in force (version effective February 1, 2013). This memorandum has been prepared using the version of Regulation 4-2-11 that became effective February 1, 2013. The memorandum will note instances where section labels are different in the May 7 guidance. To the extent that the requirements of the regulation are not applicable under federal law and regulations, the memorandum states this in the appropriate section. Where requirements of Regulation 4-2-11 conflict with federal requirements, the federal requirements are assumed to supersede the conflicting provision of state law or regulation.

The May 7 guidance requires that several elements of this memorandum be submitted in Excel format. We have attached an Excel workbook with these elements. The Excel workbook repeats information found in this memorandum, but due to the limitations of the template, it cannot contain all information to completely describe the rates. Some of the required tables are also not applicable to new products. The attached Excel workbook is merely a supplement to this memorandum and should not be read in isolation; the workbook on its own does not constitute an “Actuarial Report” as defined in Actuarial Standard of Practice No. 41.

### A. Summary

1. This rate filing is for new products to be sold on and off Connect for Health Colorado (the exchange) starting January 1, 2014.
2. This filing contains the initial rates for this product; because the products are new, this is neither a rate increase nor decrease. As well, there is no renewal history for this product.
3. These products will be marketed using brokers, radio, direct response, internet, and print media, as well as through grassroots outreach and events to educate and inform the community.
4. Under the Patient Protection and Affordable Care Act (PL 111-148 and PL 111-152; hereafter, “ACA”), premiums for the same product may vary among individuals only based on age, tobacco use, family composition, and geographic area (Public Health Service Act, §2701, as amended by the ACA, §1201).

Premiums will vary by member age, geographic area, and tobacco use status. Federal regulation clarified that for family composition, each family member must be rated as an individual, but no more than three family members under age 21 may be taken into account when calculating the premium for family coverage (45 CFR §147.102(c)). Accordingly, premiums for these products will vary by age, geographic area, and tobacco use, and each individual family member will be rated separately, except that for families with more than three children under age 21, only the first three will be counted.

5. Twelve products are covered by this rate filing:

- GoldChoice 500/30. This product has a benefit design with a gold level of coverage, as defined by the ACA, §1302(d
- GoldChoice 1000/20. This product has a benefit design with a gold level of coverage, as defined by the ACA, §1302(d).
- GoldChoice 1500/20. This product has a benefit design with a gold level of coverage, as defined by the ACA, §1302(d).
- SilverChoice HSA 1500/30. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 1750/40. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 2000/40. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 2000/Copay. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 3000/30. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- BronzeChoice HSA 3000/50. This product has a benefit design with a bronze level of coverage, as defined by the ACA, §1302(d).
- BronzeChoice 3000/50. This product has a benefit design with a bronze level of coverage, as defined by the ACA, §1302(d).
- BronzeChoice 5000/50. This product has a benefit design with a bronze level of coverage, as defined by the ACA, §1302(d).
- ValueChoice 100. This product has a benefit design with a catastrophic level of coverage, as defined by the ACA, §1302(d).

The benefit designs for the products are provided in other templates submitted with this rate filing.

For all silver plans, several variants of the benefit design will be sold to individuals who qualify for each variant. In particular, there are cost sharing reduction (CSR) variants at the 94 percent, 87 percent, and 73 percent actuarial value levels, which will be sold to those who qualify according to 45 CFR §156.420(a).

For the lowest cost bronze plan, two additional bronze plan variants are available to qualifying Native Americans, as required by 45 CFR §156.420(b): one with no cost sharing (100% actuarial value), and a second with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).

For all plans except the catastrophic plan (ValueChoice 100), a plan variant is available to qualifying Native Americans as required by 45 CFR §156.420(b), with no cost sharing for essential health

benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).

Guidance published in the Federal Register, Vol. 78, No. 47, p. 15494 (March 11, 2013) states that in non-FFE states, when a set of plan designs differ only in cost sharing and premium (as is the case for CCHP's products), a zero-cost variant for qualifying Native Americans must only be offered for the lowest-cost plan. Thus, under federal rules, a zero-cost variant is not required for anything but the lowest cost bronze product. Nonetheless, the Plan & Benefits Template, which must be submitted with this rate filing, automatically creates a zero-cost variant for all plans. It is not CCHP's intent to offer the zero-cost variant at any level except the lowest cost bronze plan unless the DOI or Connect for Health Colorado should require it, since the benefits would be identical to those of the lowest cost bronze plan, but the premium would be higher.

Each of these products provide the essential health benefits (EHB) described in the ACA, §1302. There are no supplemental (non-EHB) benefits. The federal government gave each state the flexibility to choose an EHB package based on one of ten possible benchmark options. Colorado has selected the largest small group plan in the state (Kaiser Foundation Health Plan of Colorado Deductible/Coinsurance HMO 1200D), supplemented by the pediatric dental benefits in the CHP+ program. None of the CCHP products include a pediatric dental benefit due to the expected presence of a standalone dental plan on Connect for Health Colorado. Under the ACA, §1302(b)(4)(F), a QHP is not required to offer pediatric dental benefits if a stand-alone dental plan is available on the state exchange. The DOI has established a filing deadline for stand-alone dental products that is later than the filing deadline for individual medical plans. Therefore, it cannot be known with certainty as of the filing date that a stand-alone dental plan will be available on Connect for Health Colorado. We would re-file new rates should it become necessary at a later date for CCHP to add pediatric dental benefits (if, for example, no stand-alone dental plan is filed, or none is approved by the DOI, or none is certified by Connect for Health Colorado). CCHP has no intention of offering a pediatric dental benefit in 2014 provided that a stand-alone option is available on Connect for Health Colorado. The network for these products will be a direct contracted HMO, closed panel network. As mandated, urgent and emergent care benefits are authorized out of network. No other benefits will be authorized outside of the closed panel network.

6. A list of all policy forms affected by this rate filing can be found on the Form Schedule tab, submitted along with this memorandum in SERFF.

7. (This is marked as item 6 in the May 7 guidance.) Premiums are charged on an attained-age basis, based on age at the date of policy issuance or renewal. Section K of this memorandum describes age rating in more detail. Colorado Regulation 4-2-11, Section 8A, prohibits attained age rating where the slope of the premium schedule by age is "substantially different from the slope of the ultimate claim cost curve." This requirement conflicts with 45 CFR §147.102(d)-(e), which prescribes a specific premium age curve that may not be similar to the slope of the claim cost curve. This rate filing conforms to the federal requirements.

8. (This is marked as item 7 in the May 7 guidance.) This policy is guaranteed renewable. Premiums are not guaranteed for any period after December 31, 2014.

## B. Assumption, Acquisition, or Merger

The products included in this filing are not part of an assumption, acquisition, or merger of policies from or with another company.

## C. Rating Period

The rates in this filing will be applicable January 1, 2014. Premiums will not change through the year. These rates will remain in effect until December 31, 2014 and are not guaranteed after that period.

## D. Underwriting

No underwriting is applied for these products. These are new products, and therefore contain no grandfathered plans.

## E. Effect of Law Changes

This section is labeled Section D in the May 7 guidance.

These are new products and have been designed to conform to all legal and regulatory requirements (federal and state) as of the date of this filing. Because the products are new, there are no prior rates against which changes can be measured. This filing does not account for any laws that may be signed after the date of this memorandum, nor any regulatory changes that may be issued after the date of this memorandum.

## F. Rate History

This section is labeled Section E in the May 7 guidance.

These are new products, so there is no rate history available. The Rates Template, uploaded elsewhere in SERFF, contains the proposed 2014 rates for each combination of plan design, rating area, tobacco status, and age..

## G. Coordination of Benefits

This section is labeled Section F in the May 7 guidance.

Because these are new products, there is no historical experience available. The projections of future claim costs are for CCHP's liability, net of any amounts that may be recoverable from other parties.

## H. Relation of Benefits to Premium

This section is labeled Section G in the May 7 guidance.

The targeted loss ratio is 87.56% for each product. The retention components are as follows:

**Table 1 – Retention components**

| Component | Percent of Premium |
|---|---|
| General administrative expenses | 15.00% |
| Commissions | 1.50% |
| Quality improvement expenses | 2.00% |
| Stop-loss reinsurance premium, net of recoveries | 0.00% |
| Transitional reinsurance premium, net of recoveries | -10.55% |
| Exchange administrative fee | 1.40% |
| Comparative effectiveness research fee | 0.05% |

| Table 1 – Retention components | |
|---|---|
| **Component** | **Percent of Premium** |
| Transitional reinsurance operating fee | 0.00% |
| Health insurer fee (ACA §9010, as amended) | 0.00% |
| Risk adjustment administrative fee | 0.03% |
| Investment income on reserves | 0.00% |
| Provision for profit and contingencies | 3.00% |
| **Total** | **12.44%** |

Investment income from claim reserves is included in the provision for profit and contingencies line and is expected to be immaterial in 2014.

Note that the total in the bottom row of Table 1 is not the same as the medical loss ratio that would be computed under federal rules for the purpose of determining whether a rebate is owed to members.

## I. Lifetime Loss Ratio

These products are not priced using a lifetime loss ratio.

## J. Provision for Profit and Contingencies

This section is labeled Section H in the May 7 guidance.

CCHP's provision for profit and contingencies is 3% of premium, as shown in section H. Section K explains how this provision is included in the premiums. Investment income on reserves is not expected to be material.

## K. Complete explanation as to how the proposed Rates were developed

This section is labeled Section I in the May 7 guidance.

### BACKGROUND

Under federal rules implementing the ACA (published in the Federal Register February 27, 2013, Vol. 78, No. 39, pp. 13406-13442), insurance issuers in the individual market must follow a prescribed set of guidelines in setting premiums. The basic approach is to develop a "market-wide index rate," which is applicable to all plans if the issuer sells in the individual market. To that index rate, multiplicative adjustment factors are applied to calculate an individual member's premium. Those adjustment factors are:

- Plan selection factor (due to actuarial value and cost sharing design, provider network, delivery system, and utilization management practices, benefits in addition to EHBs, administrative costs, and characteristics of catastrophic plans)
- Age factor

- Geographic area factor
- Tobacco use factor

This section of the memorandum describes the process we followed to develop the index rate for CCHP's individual products and the plan-specific adjustment factors.

In this context, an index rate is not the average claim cost or average premium for the projected insured population. Rather, the index rate is a base rate to which the factors above are applied to arrive at a premium for an individual member. It would not be mathematically possible for the index rate to represent a market average premium or claim cost for the entire insured population, because the set of age factors required by law does not have a 1.00 average (when weighted across the age profile of the insured population). The projected average claim costs and premium for this population can be found in Table 2 below, but the index rate is something different from either of these (as shown in the last row of Table 2).

## DATA

Because CCHP has no prior non-grandfathered individual product claim experience available, there is no actual CCHP claim experience available for these products. The Milliman *Health Cost Guidelines*™ (HCG) cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of CCHP's market given underwriting, rating, and benefit requirements effective January 1, 2014 under the ACA;
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Prescription Drug

Claim costs for proposed plans were developed using the HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014 under ACA. We followed the steps below to adjust the HCG claim experience to be on an appropriate basis for premiums for CCHP and to calculate the market-wide index rate and the plan-level adjustments.

### STEP 1: PROJECT TOTAL COLORADO MARKET MEMBERS AND HEALTH STATUS BY POPULATION COHORT

We expect significant shifts in the insured population when Connect for Health Colorado opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.
- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Colorado.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual and SHOP Exchanges (i.e., "take up" rates). The Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an individual Exchange plan.

We then applied employer-sponsored insurance transition rates, small group, and individual / uninsured Exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For CCHP's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

### STEP 2: PROJECT CCHP ENROLLMENT BY MARKET, EXCHANGE STATUS, AND PRODUCT

We projected CCHP's expected 2014 individual product enrollment on the exchange based on our estimate of the statewide population and CCHP's likely share of the total based on our assumed price relativity and appeal. We estimated the members that would select each of CCHP's benefit plans based on the plans for which they would qualify (given their age and income level) and assumed 8% of these members are tobacco users. We also assumed that all 2014 members are enrolled for the entire year.

### STEP 3: CLAIM COST PROJECTION

The basis used to develop rates for these new products is the 2012 HCGs. All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

### STEP 4: ADJUSTMENT FOR CHANGES IN MORBIDITY

The data in the HCGs are for a large group population. We believe this is a more appropriate basis for the development of future individual premium rates than current individual claim levels because large group experience includes a breadth of covered benefits consistent with those in the EHBs, and the impact of selection or medical underwriting present in the current individual market is mitigated by using non-underwritten large group experience. The HCGs are based on the 2012 large group population. We project that the 2014 individual market population will have a different population profile than the 2012 large group market and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the 2012 large group claims to represent our estimate of the market average demographics and morbidity of the 2014 individual market.

We projected statewide risk scores by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort. We developed an estimate that the 2014 individual market will have a 12.2% higher morbidity than the 2012 large group market, and so applied this adjustment factor to increase the claim costs. Note that this factor does not include the impact of changes in demographics, to ensure that demographic shift is not counted twice.

### STEP 5: CHANGES IN BENEFITS

The underlying utilization and charge levels assumed in the 2012 HCG baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out-of-pocket-maximum. Adjustments were made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been developed by studying the historical impact of different contractual limitations and cost sharing on utilization experience of the covered population.

### STEP 6: CHANGES IN DEMOGRAPHICS

We expect significant shifts in the demographics of the insured population when COHBE opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market. Because we are using the 2012 HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 above for more detail on these projections.

### STEP 7: ESTIMATE IMPACT OF RISK ADJUSTMENT

CCHP recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, CCHP must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant

multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of CCHP's plans in this risk pool.

Since differences between CCHP's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must be adjusted for in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which CCHP's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of CCHP's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at CCHP's expected morbidity level. The difference between the market average risk pool and CCHP's expected morbidity is our estimate of what the risk adjustment transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

### *Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected statewide risk scores (to estimate CCHP's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using MARA. We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

### *Project CCHP's Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected CCHP's risk scores (to estimate CCHP's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between CCHP and the overall Colorado market. Selection refers to the health status difference between a given carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

### *Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments*

In the CMS risk adjuster transfer formula, the average premium in the state is the basis for calculating transfer payments. We estimated statewide claim costs (to estimate the statewide premium in CCHP's risk adjustment transfer payment) by applying steps 1-6 above to estimate the per member per month (PMPM) claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. CCHP is not selling platinum products, but we did assume some percentage of take-up of those plans in the marketplace as a whole.

### *Estimate CCHP's Risk Adjustment Transfer Payment*

We estimated CCHP's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, CCHP's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether CCHP receives or makes a transfer payment is how CCHP's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding CCHP's expenses to the statewide average claim costs described above. Next, we normalized CCHP's risk score to the statewide average risk score and removed the portion of CCHP's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received (or paid) by CCHP.

### STEP 8: ESTIMATE IMPACT OF TRANSITIONAL REINSURANCE

We estimated additional costs due to the Federal transitional reinsurance program. We assumed an assessment of $5.25 PMPM in reinsurance contributions. We then assumed that CCHP will recover 80% of all individual members' per member per year (PMPY) incurred claims between $60,000 and $250,000. We estimated this value by calibrating the claims probability distributions (CPDs) from the HCGs for each of CCHP's individual benefit plans' estimated claims PMPMs.

### STEP 9: CALCULATE INDEX RATE AND PLAN-SPECIFIC ADJUSTMENTS

After estimating claim costs for both products (steps 1-6) and expected receipts under the risk adjuster program (step 7) and transitional reinsurance program (step 8), we applied the retention loads discussed in Section H of this memorandum. This results in an aggregate PMPM required premium. We then project the average of all allowable rating factors (age and plan type). The ratio of required premium to average allowable rating factor is the index rate, as shown in Table 2. Further detail on these line items can be found following Table 2.

| Table 2 – Development of required premium | |
|---|---|
| A. Expected claims, net of risk adjuster | $272.22 |
| B. Transitional reinsurance expense, net of recoveries | -$32.79 |
| C. Other administrative expenses | $62.13 |
| D. Provision for profit and contingencies | $9.33 |
| E. Total required premium (= A + B + C + D) | $310.88 |
| F. Average of allowable rating factors (age, plan type) | 1.2687 |
| **G. Index rate (= E/F)** | **$245.04** |

The amounts for administrative expenses and provision for profit and contingencies shown in Table 2 ($62.13 and $9.33) are the result of applying the retention percentages shown in Section H above.

The average allowable rating factor (1.2687) shown in Table 2 is the result of the following formula:

$$\overline{\mathrm{ARF}} = \frac{\sum_{i=1}^{n}[\mathrm{age}_i * \mathrm{plan}_i * \mathrm{area}_i * \mathrm{tobacco}_i]}{n}$$

Where:

$$\overline{\mathrm{ARF}} = \text{Average allowable rating factor}$$

$$\mathrm{age}_i = \text{Age factor for person i}$$

$$\mathrm{plan}_i = \text{Plan type factor for person i}$$

$$\mathrm{area}_i = \text{Rating factor for person i}$$

$$\mathrm{tobaco}_i = \text{Tobacco usage factor for person i}$$

$$n = \text{Total projected enrollment}$$

The age factors are shown in Addendum A, and are the ones required by the federal regulations. The plan factors are provided in Table 3.

**Table 3 – Plan factors**

| Factor | Value |
|---|---|
| GoldChoice 1500/20 | 1.0985 |
| GoldChoice 1000/20 | 1.1145 |
| GoldChoice 500/30 | 1.1147 |
| SilverChoice 1750/40 | 1.0000 |
| SilverChoice 2000/40 | 0.9906 |
| SilverChoice HSA 1500/30 | 0.9693 |
| SilverChoice 2000/Copay | 0.9806 |
| SilverChoice 3000/30 | 0.9818 |
| BronzeChoice 3000/50 | 0.7737 |
| BronzeChoice HSA 3000/50 | 0.7634 |
| BronzeChoice 5000/50 | 0.7586 |
| ValueChoice 100 | 0.7450 |

We selected SilverChoice 1750/40 as the reference point (1.0000) and estimated the remaining plans in reference to the Silver. There are no differences between the Gold and Silver plans attributable to the factors listed in 45 CFR §156.80(d)(2)(ii-iii).

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan. (Under the single risk pool requirements of 45 CFR §156.80, differences in health status may not be used to make plan-level adjustments to the market-wide index rate.)

## L. Trend

This section is labeled Section J in the May 7 guidance.

The historical experience data required by Regulation 4-2-11, Section 6L, are not available for this filing because these are new products.

As described in Section K above, the rates for these products were developed based on the 2012 HCGs. In order to produce claim costs on a 2014 basis, it was necessary to trend the claim cost projections by two years. The following medical trend assumptions were used:

**Table 4 – Annual Trend assumptions**

| Component | Utilization Trend (Annual) | Unit Cost Trend (Annual) | Total (Annual) |
|---|---|---|---|
| Inpatient facility | 0.0% | 7.0% | 7.0% |
| Outpatient facility | 2.0% | 7.5% | 9.7% |
| Professional | 1.5% | 6.0% | 7.6% |
| Prescription drugs | 2.3% | 5.8% | 8.1% |
| Other | 1.5% | 6.0% | 7.6% |
| **All Benefits** | | | **8.1%** |

These trend rates represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. These are medical trend rates; of the sources of insurance trend listed in Regulation 4-2-11, Section L5(b), only deductible leveraging is relevant for these products. Rather than apply an adjustment to the medical trend rates to account for deductible leveraging, the impact of the deductible on paid claims is directly modeled by using allowed claim levels (trended to 2014 at the rates in Table 4) in claim probability distributions also trended to 2014 levels.

## M. Credibility Considerations

This section is labeled Section K in the May 7 guidance.

This rate filing relies on data underlying the HCGs, as discussed above in Section K. The data include more than 2,000 life-years, and are therefore fully credible under Colorado Regulation 4-2-11, Section 6M.

## N. Data Requirements

This section is labeled Section L in the May 7 guidance.

CCHP's existing lines of business are significantly different from these products that the experience is not applicable. These rates have been developed using experience underlying the HCGs, as discussed in Section K above, and consistent with guidance in Actuarial Standard of Practice No. 8 regarding health rate filings for new plans or benefits.

## O. Side-by-Side Comparisons

This section is labeled Section M in the May 7 guidance.

A side-by-side comparison of current and proposed rates is not applicable, because this is an initial rate filing for new products.

Section Q below contains a list of all rating factors used. The plan design factors were developed according to the requirements of 45 CFR §156.80(d)(2). Of the permitted plan-level variations, the variation among plans is entirely due to actuarial value and cost sharing differences. Actuarial value and cost sharing differences were measured by using the HCGs to estimate the paid-to-allowed ratio and allowed claim costs for a population with standard demographics in both plan designs. By using a standard population (rather than the demographics of the projected CCHP population), we ensure that selection and health status do not affect the calculation of this factor.

CCHP has elected to employ a tobacco factor of 1.15 for all age groups.

CCHP's products are licensed in six rating areas within the state. Area factors are shown in Section Q of this memorandum. We have used eleven rating areas consistent with the recent revisions to the Colorado Geographic Rating Areas. This is not consistent with prior rating areas established in Regulation 4-6-7.

The age factors shown in Addendum A are mandated by federal regulation (see 45 CFR §147.102).

## P. Benefits Ratio Projections

This section is labeled Section N in the May 7 guidance.

The following table shows projected premium, claims, and benefits ratio for 2014. Because this is a new product, the requirement in Regulation 4-2-11 to provide this information without the rate filing is not applicable. Note that the values in this table are based on the definition of "benefits ratio" in Regulation 4-2-11. The federal MLR definition is different.

| Table 5 – Benefits ratio projection | |
|---|---|
| **Component** | **Value** |
| Projected premium, PMPM | $310.88 |
| Projected claims, net of risk adjustment receipts, PMPM | $272.22 |
| **Projected benefits ratio** | 87.56% |

## Q. Other Factors Used

The following table contains a summary of the rating factors used for these products. These are all multiplicative adjustments to the market-wide index rate of $245.04

When family coverage is purchased, each family member will be rated separately, and the sum of the individual premiums will equal the family premium, with the constraint that no more than three members under the age of 21 will contribute to the family premium.

Rating areas are those released by the Division of Insurance on March 27, 2013. Rating factors have been provided for all areas, regardless of CCHP's licensure in these areas.

| Table 6 – Rating factors | |
|---|---|
| **Factor** | **Value** |
| GoldChoice 1500/20 | 1.0985 |
| GoldChoice 1000/20 | 1.1145 |
| GoldChoice 500/30 | 1.1147 |

| Table 6 – Rating factors | |
|---|---|
| **Factor** | **Value** |
| SilverChoice 1750/40 | 1.0000 |
| SilverChoice 2000/40 | 0.9906 |
| SilverChoice HSA 1500/30 | 0.9693 |
| SilverChoice 2000/Copay | 0.9806 |
| SilverChoice 3000/30 | 0.9818 |
| BronzeChoice 3000/50 | 0.7737 |
| BronzeChoice HSA 3000/50 | 0.7634 |
| BronzeChoice 5000/50 | 0.7586 |
| ValueChoice 100 | 0.7450 |
| Tobacco surcharge | 1.1500 |
| Rating Area 1 | 0.9300 |
| Rating Area 2 | 0.8700 |
| Rating Area 3 | 0.9700 |
| Rating Area 4 | 1.1800 |
| Rating Area 5 | 1.1500 |
| Rating Area 6 | 1.2000 |
| Rating Area 7 | 0.9800 |
| Rating Area 8 | 1.0000 |
| Rating Area 9 | 1.1800 |
| Rating Area 10 | 1.0500 |
| Rating Area 11 | 1.7500 |
| Age | See Addendum A |

## R. Rating Manuals and Underwriting Guidelines

This section is labeled Section P in the May 7 guidance.

There are no underwriting guidelines applicable to these products. Section K provides a complete description of how rates are developed and how they vary from one applicant to another. The “rate manual” is attached in SERFF, and contains the same information shown in Section Q above.

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries
July 29, 2013

Milliman
1400 Wewatta Street, Suite 300
Denver, CO 80202
(303) 672-9081

## Addendum A

### AGE FACTORS

Under 45 CFR §147.102, all carriers in each state must use a standardized set of age factors. There is a federal default which is to be used in states (such as Colorado) that do not set their own factors. The following are the age factors that will be used as multiplicative adjustments to the market-wide index rate.

**Table A.1 – Age Factors**

| Age | Factor | Age | Factor |
|---|---|---|---|
| 0-20 | 0.635 | 43 | 1.357 |
| 21 | 1.000 | 44 | 1.397 |
| 22 | 1.000 | 45 | 1.444 |
| 23 | 1.000 | 46 | 1.500 |
| 24 | 1.000 | 47 | 1.563 |
| 25 | 1.004 | 48 | 1.635 |
| 26 | 1.024 | 49 | 1.706 |
| 27 | 1.048 | 50 | 1.786 |
| 28 | 1.087 | 51 | 1.865 |
| 29 | 1.119 | 52 | 1.952 |
| 30 | 1.135 | 53 | 2.040 |
| 31 | 1.159 | 54 | 2.135 |
| 32 | 1.183 | 55 | 2.230 |
| 33 | 1.198 | 56 | 2.333 |
| 34 | 1.214 | 57 | 2.437 |
| 35 | 1.222 | 58 | 2.548 |
| 36 | 1.230 | 59 | 2.603 |
| 37 | 1.238 | 60 | 2.714 |
| 38 | 1.246 | 61 | 2.810 |
| 39 | 1.262 | 62 | 2.873 |
| 40 | 1.278 | 63 | 2.952 |
| 41 | 1.302 | 64+ | 3.000 |
| 42 | 1.325 | | |

**Colorado Choice Health Plans**
**d/b/a San Luis Valley HMO**

700 Main Street, Suite 100
Alamosa, CO 81101
719-589-3696
Fax: 719-589-4901
www.coloradochoicehp.com

April 29, 2013

Mary van der Heijde, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
1400 Wewatta Street, Suite 300
Denver, CO 80202

Dear Mary:

Colorado Choice Health Plan ("Company") and Milliman, Inc. ("Milliman") have entered into a Consulting Services Agreement dated November 27, 2012 ("CSA") which includes rate filing services on Company's behalf. The CSA provides, in part, that Milliman is responsible for preparing and filing for approval with state insurance departments rate increases and form filings made by Company.

Please accept this letter as written confirmation that Milliman, pursuant to the terms and conditions of the CSA, has authority to submit form(s), rates, or certification(s) for Company through SERFF and HIOS during the 2013 year and to act on behalf of Company regarding such filings. Company may withdraw this authorization at any time, by giving written notice to Milliman.

Sincerely,

Cynthia Palmer

Cynthia Palmer
CEO

# Colorado Choice – Individual Market Rate Filing
# SERFF Tracking Number: MLCO-129025213
# Response to Objection Letter Dated 05/21/2013

**Objection 1:**

**Please correct the requested filing mode to file and use**

**Response:**

We have updated this field in SERFF

**Objection 2:**

**Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk.**

**Response:**

Thank you for this information.

**Objection 3:**

**Please provide all overall rate impact on the rate schedule tab for (0%)**

**Response:**

We have edited this information in SERFF. It now says 0% in this cell (these are new products without any existing rates against which the proposed rates can be compared).

**Objection 4:**

**Please provide the % amount on the rate rule schedule for (0%) Overall % Indicated Change: Overall % Rate Impact: Written Premium Change for this Program: # of Policy Holders Affected for this Program: Written Premium for this Program: Maximum % Change (where required): Minimum % Change (where required): Colorado Choice Health Plans New Product % % % %**

**Response:**

We have edited this information in SERFF. It now says 0% in all these cells (these are new products without any existing rates against which the proposed rates can be compared).

**Objection 5:**

- **Actuarial Memorandum and Certifications (Supporting Document)**

**Comments:**

**Regulation 4-2-11 section 6 (E) Please indicate which of the following PPACA benefits your plan has implemented:**

Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA

Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA

Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA

Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA

Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA

Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA

Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA

Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA

Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA

Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

**Response:**

We have implemented each of the following PPACA benefits:

**Table 1 – List of PPACA Benefits**

| PPACA Benefit | Implemented for 2014? |
|---|---|
| Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA | **Yes** |
| Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA | **Yes** |
| Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA | **Yes** |
| Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA | **Yes** |
| Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA | **Yes** |
| Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA | **Yes** |
| Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA | **Yes** |
| Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA | **Yes** |
| Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA | **Yes** |
| Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA | **Yes** |

**Objection 6:**

- **Actuarial Memorandum and Certifications (Supporting Document)**

  Comments:

  Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.

  1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

  2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.

  3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available.

  4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience.

  a. For Renewal filings the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.

  b. For new business filings the experience period must include consecutive data no older than nine months prior to the effective implementation date.

  The loss data must be on an incurred basis, including both separately and combined accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information about how the number of claims was calculated.

  When a carrier files a new policy form, they need to submit support for the new policy form. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy form.

  O. Side-by-Side Comparison: Each memorandum must include a “side-by-side comparison

**Response:**

These are new products without any prior experience, consistent with our response in Section L of the actuarial memorandum. Section K of the actuarial memorandum provides a detailed description of the process by which the proposed rates were developed.

Because these are new products, a side-by-side comparison would not have anything comparable for the experience period.

**Objection 7:**

- **Actuarial Memorandum and Certifications (Supporting Document)**

  Comments:

  Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: This should be annual and should match the requested Premium and claims on the view rate review detail. The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

**Response:**

Below is a tabular version of the data entered on the “requested rate” section in SERFF.

| **Benefits ratio projection** | |
|---|---|
| **Component** | **Value** |
| Projected earned premium | $49,526,255 |
| Projected incurred claims | $49,654,512 |
| **Projected benefits ratio** | **100.26%** |

Note that the rate review detail for projected incurred claims does not include risk adjuster receipts, while the benefit ratio calculation in the actuarial memorandum, Section P, does incorporate risk adjuster receipts as an offset to claims. This is the reason that the 100.26% ratio in the table above is not the same as the original table in Section P of the memorandum.

**Objection 8:**

**Please explain why your annual financials for your retention components for General expenses, commissions are different**

**Response:**

These are new products, and therefore, previous expense allocations are not appropriate. Specifically, Colorado Choice has limited experience with individual market products in the past. Additionally, the large change in the market landscape due to the PPACA introduces additional requirements and fees. We have developed new projections for retention components that we believe are more appropriate.

Therefore, the retention components in our annual statements are not intended to be replicated for these future products.

# Colorado Choice – Individual Market Rate Filing
# SERFF Tracking Number: MLCO-129025213
# Response to Objection Letter Dated 05/27/2013

**Objection 1:**

- Actuarial Memorandum and Certifications (Supporting Document)

In the final disposition letter to consumers for this filing the Division proposes to illustrate premium retained to cover expenses, profit and fees in the following format:

General Administrative Expenses: 15.0%
Commissions: 1.5%
Profit and Contingencies: 3.0%
Retention for Admin, Commissions and Profit: 19.5%
Health Insurer Fees: 0.0%
Transitional Reinsurance program Fees: 1.7%
Federal CERF: 0.03%
Federal Risk Adj Fee: 0.05%
Colorado Exchange Fee: 1.4%
Premium Retained to Pay Taxes and Fees: 3.18%
Quality Improvement: 2.01%
Total Member Premium Retained for All Purposes: 24.7%
Colorado Loss Ratio: 75.3%
Projected 2014 Federal MLR = 80.2%

Please verify each retention item in the illustration above.

We would write your Table 2 in the Actuarial Memorandum as follows:

A. Expected Claims: $270.01
B. Transitional Reinsurance Claim Recoveries: -$38.00 ( Expected claims paid by the federal program )
C1. Colorado Exchange Fees: $4.31
C2. Transitional Reinsurance Program Fees: $5.25
C3. Health Insurer Fees: $0.00
C4. CERF Fee: $0.09
C5. Risk Adjustment Fee: $0.15
C6. Administrative Expenses: $46.21
C7. Commissions: $4.62
C8. Quality Improvement Expenses: $6.19
D. Profit and Contingencies: $9.24
E. Total Required premium: $308.07
Retention = ( C1 + C2 + C3 + C4 + C5 + C6 + C7 + C8 ) + D = $76.06
Retention % = $76.06 / $308.07 = 24.7%
Loss ratio = 1 - Retention = 75.3% = $232.01 / $308.07 = expected losses / expected premium, which is the definition of anticipated loss ratio in the alignment bill.

**Response:**

With the exception of reversing the CERF fee and the Risk Adjustment Fee in the retention components listed, we can verify that the retention components listed in your objection are correct. Consistent with Table 1 of the Actuarial Memorandum, the CERF fee should be listed as 0.05 percent of premium, and the risk adjustment fee should be listed as 0.03 percent of premium. Table 1 in our Actuarial Memo also includes Transitional Reinsurance Claim Recoveries. As noted, the Medical Loss Ratio, according to the federal calculation is 80.2 percent.

We have provided an updated version of Table 2, consistent with your interpretation, but with corrections to the CERF and Risk Adjustment fees, below:

| Table 2 – Development of Required Premium | |
|---|---|
| **Premium Component** | **Amount** |
| A. Expected claims, net of risk adjuster | $270.01 |
| B. Transitional reinsurance claim recoveries | -$38.00 |
| C1. Colorado Exchange fees | $4.31 |
| C2. Transitional reinsurance program fees | $5.25 |
| C3. Health insurer fees | $0.00 |
| C4. CERF fee | $0.15 |
| C5. Risk adjustment fee | $0.09 |
| C6. Administrative expenses | $46.21 |
| C7. Commissions | $4.62 |
| C8. Quality improvement expenses | $6.19 |
| D. Provision for profit and contingencies | $9.24 |
| E. Total required premium | $308.07 |
| F. Average of allowable rating factors (age, plan type) | 1.2788 |
| **G. Index rate (= E/F)** | $240.90 |

Your calculation of retention components based on the alignment bill is consistent with our intent. While this approach develops a loss ratio of 75.3 percent using this definition, as noted above the federal MLR calculation is 80.2 percent.

## Objection 2:

- Actuarial Memorandum and Certifications (Supporting Document)

Comments:
The PPAC A final Market Rule defines Plan Level Adjustments to be the following specific rating adjustments (45 CFR Part 156.80(d)2):

"Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(i) The actuarial value and cost-sharing design of the plan.

(ii) The plan's provider network, delivery system characteristics, and utilization management practices.

(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(iv) Administrative costs, excluding Exchange user fees.

(v) With respect to catastrophic plans, the expected impact of the specific eligibility"

Please provide each of these specific Plan Level rating adjustments that you are applying for each plan in this rate filing, show how they roll up to your total Plan Rating Factor shown for each plan.

## Response:

We are only using the five permitted plan-level adjustments to the index rate. Attachment A of the Part III Actuarial Memorandum (repeated below for convenience) contains a breakdown of the development of these plan-level adjustment factors.

**Attachment A – AV Pricing Value Breakdown Summary**

| Plan | AV Pricing Value | Adjust 1 AV/Cost Share | Adjust 2 Network | Adjust 3 Other Benefits | Adjust 4 Admin Expense | Adjust 5 Catastrophic | Total |
|---|---|---|---|---|---|---|---|
| GoldChoice 1000/20 | 1.1312 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| GoldChoice 1500/20 | 1.1149 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| GoldChoice 500/30 | 1.1313 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 1500/50 | 1.0000 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 2000/40 | 1.0054 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice HSA 1500/30 | 0.9838 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 2000/50 | 0.9636 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 3000/30 | 0.9964 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice 5000/50 | 0.7700 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice 3000/50 | 0.7852 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice HSA 3000/50 | 0.7748 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| ValueChoice 100 | 0.7561 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |

For the AV pricing value, all are presented with respect to the SilverChoice 1500/50 because our index rate is developed for this product. Note that we are applying a consistent administrative load and network to each plan. Additionally, we are not providing non-EHBs and have not made an eligibility-related adjustment to the factor for the catastrophic plan.

# Colorado Choice – Individual Market Rate Filing
# SERFF Tracking Number: MLCO-129025213
# Response to Objection Letter Dated 06/05/2013

**Objection 1:**

objection 6 Regulation 4-2-11 section 6 (N) The experience needs to be provided on how the rates were developed. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided.

**Response:**

This section of regulation 4-2-11 specifies that experience be provided for the product in question, if available, or for a comparable product, if available. There is no experience available to provide for either the filed product or any comparable ones, because:

- Colorado Choice has not previously sold these products, and
- The changes caused by the Affordable Care Act make all of Colorado Choice's other existing products not comparable to its proposed 2014 individual products.
- All prior experience is for grandfathered products

Colorado Choice's experience with individual market products is extremely limited. This experience is neither relevant (due to the reasons listed above) nor credible (due to the very limited enrollment). Nonetheless, below are the experience for these few members (and again, we emphasize that this experience was not and should not have been relied upon to develop the rates in this filing, and we do not believe this experience is relevant to Regulation 4-2-11, Section 6N):

| Individual Market Experience | | | |
|---|---|---|---|
| | **2010** | **2011** | **2012** |
| **Life-Years** | 199 | 189 | 179 |
| **Medical Claims** | $685,172 | $467,043 | $748,352 |
| **Rx Claims** | $20,053 | $7,100 | $4,542 |
| **Total Claims** | $705,225 | $474,143 | $752,894 |
| **PMPM Claims** | $295.57 | $209.43 | $350.51 |

Section K of the memorandum contains extensive detail describing how the rates were developed. We did not rely on this experience in the development of future rates. We would be happy to schedule a phone conversation to discuss our methodology should the Division have specific questions that are not directly addressed in Section K.

# Colorado Choice – Individual Market Rate Filing
# SERFF Tracking Number: MLCO-129025213
# Response to Objection Letter Dated 06/14/2013

**Objection 1:**

Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.

**Response:**

In the instructions for the URRT issued on April 29, 2013, the Index Rate is described as follows:

> *"As noted in Section I, the index rate represents the average allowed claims PMPM for essential health benefits. This legal entity-specific rate for the projection period should not reflect any adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply projected allowed claims PMPM for essential health benefits."*

Based on this guidance, we set the Index Rate in the URRT to the Allowed Claims PMPM before reinsurance and risk adjustment. Note that the Index Rate provided in the URRT is not explicitly used in developing premiums. Factors for allowable rating characteristics including plan factors, age factors, area factors, and smoking factors were applied to a base rate of $240.90 to develop rates. To arrive at this, the total Projected Allowed Claims were converted to projected incurred claims by applying the average paid-to-allowed factor. Non-claims expenses were then applied to arrive at the average carrier premium. A plan factor for each projected member cohort was developed using a product of the ACA allowable rating characteristics. Note that this number is slightly different than the product of the average of each separate allowable rating characteristic. The average premium of $308.07 was divided by the membership weighted average total rating factor of 1.279 to arrive at a base rate of $240.90 from which all premiums were determined.

| Quantitative Support | |
|---|---|
| Projected Allowed Claims Experience | $448.61 |
| Times: Average Paid-to-Allowed Factor | 0.689 |
| Equals: Projected Incurred Claims | $308.87 |
| Plus: Administrative Expenses | $61.57 |
| Plus: Risk Adjuster Paid (Received) | -$38.86 |
| Plus: Federal Reinsurance Paid (Received) | -$32.75 |
| Plus: Target Profit | $9.24 |
| Equals: Average Premium | $308.07 |
| | |
| Average Area Factor: | 1.022 |
| Average Age Factor | 1.287 |
| Average Tobacco Factor | 1.010 |
| Average Plan Factor | 0.963 |
| Membership Weighted Average of Total Rating Factor | 1.279 |
| | |
| Average Premium | $308.07 |
| Divided By: Weighted Average of Total Rating Factor | 1.279 |
| Equals: Base Rate Used in Pricing | $240.90 |

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date | Schedule Item Status | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---|---|---|---|---|---|
| 05/14/2013 | | Supporting Document | Rate Sample | 07/29/2013 | State of Colorado - Rate Sample Individual.xlsx (Superceded) |
| 05/13/2013 | | Rate | Rating Manual - CCHP Individual Market | 07/29/2013 | Rating Manual - CCHP Individual Market Plans.pdf (Superceded) |
| 05/10/2013 | | Supporting Document | Actuarial Memorandum and Certifications | 07/29/2013 | Milliman - Actuarial Certification - CCHP Individual Products 2013-05-14.pdf (Superceded)<br>Milliman - Actuarial memorandum - CCHP Individual Products 2013-05-14.pdf (Superceded)<br>Milliman - CCHP Part III memorandum - Individual 2013-05-14.pdf (Superceded)<br>Individual Actuarial Memorandum Template (populated) 5-14-2013.xlsx (Superceded) |
| 05/10/2013 | | Supporting Document | Unified Rate Review Template | 07/29/2013 | CCHP - Individual URRT 5-7-2013.xlsm (Superceded) |

| | | | | | |
|---|---|---|---|---|---|
| **SERFF Tracking #:** | MLCO-129025213 | **State Tracking #:** | 278052 | **Company Tracking #:** | |

| | | | |
|---|---|---|---|
| **State:** | Colorado | **Filing Company:** | Colorado Choice Health Plans |
| **TOI/Sub-TOI:** | HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO | | |
| **Product Name:** | Colorado Choice - Individual Market | | |
| **Project Name/Number:** | / | | |

***Attachment State of Colorado - Rate Sample Individual.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment Individual Actuarial Memorandum Template (populated) 5-14-2013.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment CCHP - Individual URRT 5-7-2013.xlsm is not a PDF document and cannot be reproduced here.***

# Colorado Choice Health Plans
## Individual Rating Manual

**Base Rate** 240.90

| Plan | Rate Factor |
|---|---|
| GoldChoice 1000/20 | 1.1312 |
| GoldChoice 1500/20 | 1.1149 |
| GoldChoice 500/30 | 1.1313 |
| SilverChoice 1500/50 | 1.0000 |
| SilverChoice 2000/40 | 1.0054 |
| SilverChoice HSA 1500/30 | 0.9838 |
| SilverChoice 2000/50 | 0.9636 |
| SilverChoice 3000/30 | 0.9964 |
| BronzeChoice 5000/50 | 0.7700 |
| BronzeChoice 3000/50 | 0.7852 |
| BronzeChoice HSA 3000/50 | 0.7748 |
| ValueChoice 100 | 0.7561 |

**Tobacco Factors**

| Age Band | Rate Factor |
|---|---|
| 0-20 | 1.150 |
| 21-24 | 1.150 |
| 25-29 | 1.150 |
| 30-34 | 1.150 |
| 35-39 | 1.150 |
| 40-44 | 1.150 |
| 45-49 | 1.150 |
| 50-54 | 1.150 |
| 55-59 | 1.150 |
| 60-63 | 1.150 |
| 64+ | 1.150 |

**Geographic Factors**

| Area | Rate Factor |
|---|---|
| Rating Area 2 | 0.870 |
| Rating Area 3 | 0.970 |
| Rating Area 4 | 1.180 |
| Rating Area 6 | 1.200 |
| Rating Area 8 | 1.000 |
| Rating Area 9 | 1.180 |

| Age Band | Rate Factor |
|---|---|
| 0-20 | 0.635 |
| 21 | 1.000 |
| 22 | 1.000 |
| 23 | 1.000 |
| 24 | 1.000 |
| 25 | 1.004 |
| 26 | 1.024 |
| 27 | 1.048 |
| 28 | 1.087 |
| 29 | 1.119 |
| 30 | 1.135 |
| 31 | 1.159 |
| 32 | 1.183 |
| 33 | 1.198 |
| 34 | 1.214 |
| 35 | 1.222 |
| 36 | 1.230 |
| 37 | 1.238 |
| 38 | 1.246 |
| 39 | 1.262 |
| 40 | 1.278 |
| 41 | 1.302 |
| 42 | 1.325 |
| 43 | 1.357 |
| 44 | 1.397 |
| 45 | 1.444 |
| 46 | 1.500 |
| 47 | 1.563 |
| 48 | 1.635 |
| 49 | 1.706 |
| 50 | 1.786 |
| 51 | 1.865 |
| 52 | 1.952 |
| 53 | 2.040 |
| 54 | 2.135 |
| 55 | 2.230 |
| 56 | 2.333 |
| 57 | 2.437 |
| 58 | 2.548 |
| 59 | 2.603 |
| 60 | 2.714 |
| 61 | 2.810 |
| 62 | 2.873 |
| 63 | 2.952 |
| 64+ | 3.000 |

# ACTUARIAL CERTIFICATION

## Colorado Choice Health Plans
## Individual Rate Filing Effective January 1, 2014
## GoldChoice 500/30, GoldChoice 1000/20, GoldChoice 1500/20, SilverChoice HSA 1500/30, SilverChoice 1500/50, SilverChoice 2000/40, SilverChoice 2000/50, SilverChoice 3000/30, BronzeChoice HSA 3000/50, BronzeChoice 3000/50, ValueChoice 100

I, Mary van der Heijde, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by Colorado Choice Health Plans (CCHP) to render this opinion. I meet the Academy qualification standards for rendering the opinion and am familiar with the applicable Colorado statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for individual rate filings. I am qualified to render this opinion under the qualifications set forth in Colorado Insurance Regulation 1-1-1.

In particular, this certification is being prepared to demonstrate compliance with Colorado Regulation 4-2-11, as promulgated under the authority of C.R.S. 10-1-109, 10-3-1110, 10-16-107, 10-16-109, and 10-18-105(2). It is not intended to be used for any other purpose.

### Actuarial Certification

To the best of my knowledge, this rate filing is in compliance with the applicable laws and regulations of the State of Colorado in effect as of May 14, 2013, except where those laws and regulations conflict with the Patient Protection and Affordable Care Act and its implementing regulations. In cases where Colorado law or regulation is in conflict with federal law or regulation, this rate filing complies with federal law or regulation or regulatory guidance. In my opinion, the premium rates described in my Actuarial Memorandum dated May 14, 2013, are not excessive, inadequate, or unfairly discriminatory.

_____

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries
May 14, 2013

# ACTUARIAL MEMORANDUM

## Colorado Choice Health Plans
## Individual Rate Filing Effective January 1, 2014
## GoldChoice 500/30, GoldChoice 1000/20, GoldChoice 1500/20, SilverChoice HSA 1500/30, SilverChoice 1500/50, SilverChoice 2000/40, SilverChoice 2000/50, SilverChoice 3000/30, BronzeChoice HSA 3000/50, BronzeChoice 3000/50, ValueChoice 100

I, Mary van der Heijde, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by Colorado Choice Health Plans (CCHP) to prepare this memorandum. I meet the Academy qualification standards for rendering the opinion that accompanies this memorandum (dated May 14, 2013) and am familiar with the applicable Colorado statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for individual rate filings. I am qualified to render this opinion under the qualifications set forth in Colorado Insurance Regulation 1-1-1.

In particular, this memorandum is being prepared to demonstrate compliance with Colorado Regulation 4-2-11, as promulgated under the authority of C.R.S. 10-1-109, 10-3-1110, 10-16-107, 10-16-109, and 10-18-105(2). It is not intended to be used for any other purpose.

The Colorado Division of Insurance (DOI) released a document on May 7, 2013, entitled “PPACA Rate Filing Procedures for Colorado” (hereafter, “the May 7 guidance”). This document describes the desired content of the actuarial memorandum, and it differs in some ways from the instructions in Regulation 4-2-11 as currently in force (version effective February 1, 2013). This memorandum has been prepared using the version of Regulation 4-2-11 that became effective February 1, 2013. The memorandum will note instances where section labels are different in the May 7 guidance. To the extent that the requirements of the regulation are not applicable under federal law and regulations, the memorandum states this in the appropriate section. Where requirements of Regulation 4-2-11 conflict with federal requirements, the federal requirements are assumed to supersede the conflicting provision of state law or regulation.

The May 7 guidance requires that several elements of this memorandum be submitted in Excel format. We have attached an Excel workbook with these elements. The Excel workbook repeats information found in this memorandum, but due to the limitations of the template, it cannot contain all information to completely describe the rates. Some of the required tables are also not applicable to new products. The attached Excel workbook is merely a supplement to this memorandum and should not be read in isolation; the workbook on its own does not constitute an “Actuarial Report” as defined in Actuarial Standard of Practice No. 41.

### A. Summary

1. This rate filing is for new products to be sold on and off Connect for Health Colorado (the exchange) starting January 1, 2014.
2. This filing contains the initial rates for this product; because the products are new, this is neither a rate increase nor decrease. As well, there is no renewal history for this product.
3. These products will be marketed using brokers, radio, direct response, internet, and print media, as well as through grassroots outreach and events to educate and inform the community.
4. Under the Patient Protection and Affordable Care Act (PL 111-148 and PL 111-152; hereafter, “ACA”), premiums for the same product may vary among individuals only based on age, tobacco use, family composition, and geographic area (Public Health Service Act, §2701, as amended by the ACA, §1201).

Premiums will vary by member age, geographic area, and tobacco use status. Federal regulation clarified that for family composition, each family member must be rated as an individual, but no more than three family members under age 21 may be taken into account when calculating the premium for family coverage (45 CFR §147.102(c)). Accordingly, premiums for these products will vary by age, geographic area, and tobacco use, and each individual family member will be rated separately, except that for families with more than three children under age 21, only the first three will be counted.

5. Twelve products are covered by this rate filing:

- GoldChoice 500/30. This product has a benefit design with a gold level of coverage, as defined by the ACA, §1302(d
- GoldChoice 1000/20. This product has a benefit design with a gold level of coverage, as defined by the ACA, §1302(d).
- GoldChoice 1500/20. This product has a benefit design with a gold level of coverage, as defined by the ACA, §1302(d).
- SilverChoice HSA 1500/30. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 1500/50. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 2000/40. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 2000/50. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- SilverChoice 3000/30. This product has a benefit design with a silver level of coverage, as defined by the ACA, §1302(d).
- BronzeChoice HSA 3000/50. This product has a benefit design with a bronze level of coverage, as defined by the ACA, §1302(d).
- BronzeChoice 3000/50. This product has a benefit design with a bronze level of coverage, as defined by the ACA, §1302(d).
- BronzeChoice 5000/50. This product has a benefit design with a bronze level of coverage, as defined by the ACA, §1302(d).
- ValueChoice 100. This product has a benefit design with a catastrophic level of coverage, as defined by the ACA, §1302(d).

The benefit designs for the products are provided in other templates submitted with this rate filing.

For all silver plans, several variants of the benefit design will be sold to individuals who qualify for each variant. In particular, there are cost sharing reduction (CSR) variants at the 94 percent, 87 percent, and 73 percent actuarial value levels, which will be sold to those who qualify according to 45 CFR §156.420(a).

For the lowest cost bronze plan, two additional bronze plan variants are available to qualifying Native Americans, as required by 45 CFR §156.420(b): one with no cost sharing (100% actuarial value), and a second with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).

For all plans except the catastrophic plan (ValueChoice 100), a plan variant is available to qualifying Native Americans as required by 45 CFR §156.420(b), with no cost sharing for essential health

benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).

Guidance published in the Federal Register, Vol. 78, No. 47, p. 15494 (March 11, 2013) states that in non-FFE states, when a set of plan designs differ only in cost sharing and premium (as is the case for CCHP's products), a zero-cost variant for qualifying Native Americans must only be offered for the lowest-cost plan. Thus, under federal rules, a zero-cost variant is not required for anything but the lowest cost bronze product. Nonetheless, the Plan & Benefits Template, which must be submitted with this rate filing, automatically creates a zero-cost variant for all plans. It is not CCHP's intent to offer the zero-cost variant at any level except the lowest cost bronze plan unless the DOI or Connect for Health Colorado should require it, since the benefits would be identical to those of the lowest cost bronze plan, but the premium would be higher.

Each of these products provide the essential health benefits (EHB) described in the ACA, §1302. There are no supplemental (non-EHB) benefits. The federal government gave each state the flexibility to choose an EHB package based on one of ten possible benchmark options. Colorado has selected the largest small group plan in the state (Kaiser Foundation Health Plan of Colorado Deductible/Coinsurance HMO 1200D), supplemented by the pediatric dental benefits in the CHP+ program. None of the CCHP products include a pediatric dental benefit due to the expected presence of a standalone dental plan on Connect for Health Colorado. Under the ACA, §1302(b)(4)(F), a QHP is not required to offer pediatric dental benefits if a stand-alone dental plan is available on the state exchange. The DOI has established a filing deadline for stand-alone dental products that is later than the filing deadline for individual medical plans. Therefore, it cannot be known with certainty as of the filing date that a stand-alone dental plan will be available on Connect for Health Colorado. We would re-file new rates should it become necessary at a later date for CCHP to add pediatric dental benefits (if, for example, no stand-alone dental plan is filed, or none is approved by the DOI, or none is certified by Connect for Health Colorado). CCHP has no intention of offering a pediatric dental benefit in 2014 provided that a stand-alone option is available on Connect for Health Colorado. The network for these products will be a direct contracted HMO, closed panel network. As mandated, urgent and emergent care benefits are authorized out of network. No other benefits will be authorized outside of the closed panel network.

6. A list of all policy forms affected by this rate filing can be found on the Form Schedule tab, submitted along with this memorandum in SERFF.

7. (This is marked as item 6 in the May 7 guidance.) Premiums are charged on an attained-age basis, based on age at the date of policy issuance or renewal. Section K of this memorandum describes age rating in more detail. Colorado Regulation 4-2-11, Section 8A, prohibits attained age rating where the slope of the premium schedule by age is "substantially different from the slope of the ultimate claim cost curve." This requirement conflicts with 45 CFR §147.102(d)-(e), which prescribes a specific premium age curve that may not be similar to the slope of the claim cost curve. This rate filing conforms to the federal requirements.

8. (This is marked as item 7 in the May 7 guidance.) This policy is guaranteed renewable. Premiums are not guaranteed for any period after December 31, 2014.

## B. Assumption, Acquisition, or Merger

The products included in this filing are not part of an assumption, acquisition, or merger of policies from or with another company.

## C. Rating Period

The rates in this filing will be applicable January 1, 2014. Premiums will not change through the year. These rates will remain in effect until December 31, 2014 and are not guaranteed after that period.

## D. Underwriting

No underwriting is applied for these products. These are new products, and therefore contain no grandfathered plans.

## E. Effect of Law Changes

This section is labeled Section D in the May 7 guidance.

These are new products and have been designed to conform to all legal and regulatory requirements (federal and state) as of the date of this filing. Because the products are new, there are no prior rates against which changes can be measured. This filing does not account for any laws that may be signed after the date of this memorandum, nor any regulatory changes that may be issued after the date of this memorandum.

## F. Rate History

This section is labeled Section E in the May 7 guidance.

These are new products, so there is no rate history available. The Rates Template, uploaded elsewhere in SERFF, contains the proposed 2014 rates for each combination of plan design, rating area, tobacco status, and age..

## G. Coordination of Benefits

This section is labeled Section F in the May 7 guidance.

Because these are new products, there is no historical experience available. The projections of future claim costs are for CCHP's liability, net of any amounts that may be recoverable from other parties.

## H. Relation of Benefits to Premium

This section is labeled Section G in the May 7 guidance.

The targeted loss ratio is 87.64% for each product. The retention components are as follows:

**Table 1 – Retention components**

| Component | Percent of Premium |
|---|---|
| General administrative expenses | 15.00% |
| Commissions | 1.50% |
| Quality improvement expenses | 2.01% |
| Stop-loss reinsurance premium, net of recoveries | 0.00% |
| Transitional reinsurance premium, net of recoveries | -10.63% |
| Exchange administrative fee | 1.40% |
| Comparative effectiveness research fee | 0.05% |

| Table 1 – Retention components | |
|---|---|
| **Component** | **Percent of Premium** |
| Transitional reinsurance operating fee | 0.00% |
| Health insurer fee (ACA §9010, as amended) | 0.00% |
| Risk adjustment administrative fee | 0.03% |
| Investment income on reserves | 0.00% |
| Provision for profit and contingencies | 3.00% |
| **Total** | **12.36%** |

Investment income from claim reserves is included in the provision for profit and contingencies line and is expected to be immaterial in 2014.

Note that the total in the bottom row of Table 1 is not the same as the medical loss ratio that would be computed under federal rules for the purpose of determining whether a rebate is owed to members.

## I. Lifetime Loss Ratio

These products are not priced using a lifetime loss ratio.

## J. Provision for Profit and Contingencies

This section is labeled Section H in the May 7 guidance.

CCHP's provision for profit and contingencies is 3% of premium, as shown in section H. Section K explains how this provision is included in the premiums. Investment income on reserves is not expected to be material.

## K. Complete explanation as to how the proposed Rates were developed

This section is labeled Section I in the May 7 guidance.

### BACKGROUND

Under federal rules implementing the ACA (published in the Federal Register February 27, 2013, Vol. 78, No. 39, pp. 13406-13442), insurance issuers in the individual market must follow a prescribed set of guidelines in setting premiums. The basic approach is to develop a "market-wide index rate," which is applicable to all plans if the issuer sells in the individual market. To that index rate, multiplicative adjustment factors are applied to calculate an individual member's premium. Those adjustment factors are:

- Plan selection factor (due to actuarial value and cost sharing design, provider network, delivery system, and utilization management practices, benefits in addition to EHBs, administrative costs, and characteristics of catastrophic plans)
- Age factor

- Geographic area factor
- Tobacco use factor

This section of the memorandum describes the process we followed to develop the index rate for CCHP's individual products and the plan-specific adjustment factors.

In this context, an index rate is not the average claim cost or average premium for the projected insured population. Rather, the index rate is a base rate to which the factors above are applied to arrive at a premium for an individual member. It would not be mathematically possible for the index rate to represent a market average premium or claim cost for the entire insured population, because the set of age factors required by law does not have a 1.00 average (when weighted across the age profile of the insured population). The projected average claim costs and premium for this population can be found in Table 2 below, but the index rate is something different from either of these (as shown in the last row of Table 2).

## DATA

Because CCHP has no prior non-grandfathered individual product claim experience available, there is no actual CCHP claim experience available for these products. The Milliman *Health Cost Guidelines*™ (HCG) cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of CCHP's market given underwriting, rating, and benefit requirements effective January 1, 2014 under the ACA;
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Prescription Drug

Claim costs for proposed plans were developed using the HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014 under ACA. We followed the steps below to adjust the HCG claim experience to be on an appropriate basis for premiums for CCHP and to calculate the market-wide index rate and the plan-level adjustments.

### STEP 1: PROJECT TOTAL COLORADO MARKET MEMBERS AND HEALTH STATUS BY POPULATION COHORT

We expect significant shifts in the insured population when Connect for Health Colorado opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.
- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Colorado.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual and SHOP Exchanges (i.e., "take up" rates). The Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an individual Exchange plan.

We then applied employer-sponsored insurance transition rates, small group, and individual / uninsured Exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For CCHP's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

### STEP 2: PROJECT CCHP ENROLLMENT BY MARKET, EXCHANGE STATUS, AND PRODUCT

We projected CCHP's expected 2014 individual product enrollment on the exchange based on our estimate of the statewide population and CCHP's likely share of the total based on our assumed price relativity and appeal. We estimated the members that would select each of CCHP's benefit plans based on the plans for which they would qualify (given their age and income level) and assumed 8% of these members are tobacco users. We also assumed that all 2014 members are enrolled for the entire year.

### STEP 3: CLAIM COST PROJECTION

The basis used to develop rates for these new products is the 2012 HCGs. All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

### STEP 4: ADJUSTMENT FOR CHANGES IN MORBIDITY

The data in the HCGs are for a large group population. We believe this is a more appropriate basis for the development of future individual premium rates than current individual claim levels because large group experience includes a breadth of covered benefits consistent with those in the EHBs, and the impact of selection or medical underwriting present in the current individual market is mitigated by using non-underwritten large group experience. The HCGs are based on the 2012 large group population. We project that the 2014 individual market population will have a different population profile than the 2012 large group market and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the 2012 large group claims to represent our estimate of the market average demographics and morbidity of the 2014 individual market.

We projected statewide risk scores by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort. We developed an estimate that the 2014 individual market will have a 12.2% higher morbidity than the 2012 large group market, and so applied this adjustment factor to increase the claim costs. Note that this factor does not include the impact of changes in demographics, to ensure that demographic shift is not counted twice.

### STEP 5: CHANGES IN BENEFITS

The underlying utilization and charge levels assumed in the 2012 HCG baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out-of-pocket-maximum. Adjustments were made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been developed by studying the historical impact of different contractual limitations and cost sharing on utilization experience of the covered population.

### STEP 6: CHANGES IN DEMOGRAPHICS

We expect significant shifts in the demographics of the insured population when COHBE opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market. Because we are using the 2012 HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 above for more detail on these projections.

### STEP 7: ESTIMATE IMPACT OF RISK ADJUSTMENT

CCHP recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, CCHP must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant

multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of CCHP's plans in this risk pool.

Since differences between CCHP's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must be adjusted for in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which CCHP's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of CCHP's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at CCHP's expected morbidity level. The difference between the market average risk pool and CCHP's expected morbidity is our estimate of what the risk adjustment transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

### *Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected statewide risk scores (to estimate CCHP's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using MARA. We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

### *Project CCHP's Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected CCHP's risk scores (to estimate CCHP's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between CCHP and the overall Colorado market. Selection refers to the health status difference between a given carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

### *Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments*

In the CMS risk adjuster transfer formula, the average premium in the state is the basis for calculating transfer payments. We estimated statewide claim costs (to estimate the statewide premium in CCHP's risk adjustment transfer payment) by applying steps 1-6 above to estimate the per member per month (PMPM) claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. CCHP is not selling platinum products, but we did assume some percentage of take-up of those plans in the marketplace as a whole.

### *Estimate CCHP's Risk Adjustment Transfer Payment*

We estimated CCHP's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, CCHP's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether CCHP receives or makes a transfer payment is how CCHP's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding CCHP's expenses to the statewide average claim costs described above. Next, we normalized CCHP's risk score to the statewide average risk score and removed the portion of CCHP's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received (or paid) by CCHP.

### STEP 8: ESTIMATE IMPACT OF TRANSITIONAL REINSURANCE

We estimated additional costs due to the Federal transitional reinsurance program. We assumed an assessment of $5.25 PMPM in reinsurance contributions. We then assumed that CCHP will recover 80% of all individual members' per member per year (PMPY) incurred claims between $60,000 and $250,000. We estimated this value by calibrating the claims probability distributions (CPDs) from the HCGs for each of CCHP's individual benefit plans' estimated claims PMPMs.

### STEP 9: CALCULATE INDEX RATE AND PLAN-SPECIFIC ADJUSTMENTS

After estimating claim costs for both products (steps 1-6) and expected receipts under the risk adjuster program (step 7) and transitional reinsurance program (step 8), we applied the retention loads discussed in Section H of this memorandum. This results in an aggregate PMPM required premium. We then project the average of all allowable rating factors (age and plan type). The ratio of required premium to average allowable rating factor is the index rate, as shown in Table 2. Further detail on these line items can be found following Table 2.

| Table 2 – Development of required premium | |
|---|---|
| A. Expected claims, net of risk adjuster | $270.01 |
| B. Transitional reinsurance expense, net of recoveries | -$32.75 |
| C. Other administrative expenses | $61.57 |
| D. Provision for profit and contingencies | $9.24 |
| E. Total required premium (= A + B + C + D) | $308.07 |
| F. Average of allowable rating factors (age, plan type) | 1.2788 |
| **G. Index rate (= E/F)** | **$240.90** |

The amounts for administrative expenses and provision for profit and contingencies shown in Table 2 ($61.57 and $9.24) are the result of applying the retention percentages shown in Section H above.

The average allowable rating factor (1.2788) shown in Table 2 is the result of the following formula:

$$\overline{\mathrm{ARF}} = \frac{\sum_{i=1}^{n}[\mathrm{age}_i * \mathrm{plan}_i * \mathrm{area}_i * \mathrm{tobacco}_i]}{n}$$

Where:

$$\overline{\mathrm{ARF}} = \text{Average allowable rating factor}$$

$$\mathrm{age}_i = \text{Age factor for person i}$$

$$\mathrm{plan}_i = \text{Plan type factor for person i}$$

$$\mathrm{area}_i = \text{Rating factor for person i}$$

$$\mathrm{tobaco}_i = \text{Tobacco usage factor for person i}$$

$$n = \text{Total projected enrollment}$$

The age factors are shown in Addendum A, and are the ones required by the federal regulations. The plan factors are provided in Table 3.

**Table 3 – Plan factors**

| Factor | Value |
|---|---|
| GoldChoice 1500/20 | 1.1149 |
| GoldChoice 1000/20 | 1.1312 |
| GoldChoice 500/30 | 1.1313 |
| SilverChoice 1500/50 | 1.0000 |
| SilverChoice 2000/40 | 1.0054 |
| SilverChoice HSA 1500/30 | 0.9838 |
| SilverChoice 2000/50 | 0.9636 |
| SilverChoice 3000/30 | 0.9964 |
| BronzeChoice 3000/50 | 0.7852 |
| BronzeChoice HSA 3000/50 | 0.7748 |
| BronzeChoice 5000/50 | 0.7700 |
| ValueChoice 100 | 0.7561 |

We selected SilverChoice 1500/50 as the reference point (1.0000) and estimated the remaining plans in reference to the silver. There are no differences between the Gold and Silver plans attributable to the factors listed in 45 CFR §156.80(d)(2)(ii-iii).

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan. (Under the single risk pool requirements of 45 CFR §156.80, differences in health status may not be used to make plan-level adjustments to the market-wide index rate.)

## L. Trend

This section is labeled Section J in the May 7 guidance.

The historical experience data required by Regulation 4-2-11, Section 6L, are not available for this filing because these are new products.

As described in Section K above, the rates for these products were developed based on the 2012 HCGs. In order to produce claim costs on a 2014 basis, it was necessary to trend the claim cost projections by two years. The following medical trend assumptions were used:

**Table 4 – Annual Trend assumptions**

| Component | Utilization Trend (Annual) | Unit Cost Trend (Annual) | Total (Annual) |
|---|---|---|---|
| Inpatient facility | 0.0% | 7.0% | 7.0% |
| Outpatient facility | 2.0% | 7.5% | 9.7% |
| Professional | 1.5% | 6.0% | 7.6% |
| Prescription drugs | 2.3% | 5.8% | 8.1% |
| Other | 1.5% | 6.0% | 7.6% |
| **All Benefits** | | | **8.1%** |

These trend rates represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. These are medical trend rates; of the sources of insurance trend listed in Regulation 4-2-11, Section L5(b), only deductible leveraging is relevant for these products. Rather than apply an adjustment to the medical trend rates to account for deductible leveraging, the impact of the deductible on paid claims is directly modeled by using allowed claim levels (trended to 2014 at the rates in Table 4) in claim probability distributions also trended to 2014 levels.

## M. Credibility Considerations

This section is labeled Section K in the May 7 guidance.

This rate filing relies on data underlying the HCGs, as discussed above in Section K. The data include more than 2,000 life-years, and are therefore fully credible under Colorado Regulation 4-2-11, Section 6M.

## N. Data Requirements

This section is labeled Section L in the May 7 guidance.

CCHP's existing lines of business are significantly different from these products that the experience is not applicable. These rates have been developed using experience underlying the HCGs, as discussed in Section K above, and consistent with guidance in Actuarial Standard of Practice No. 8 regarding health rate filings for new plans or benefits.

## O. Side-by-Side Comparisons

This section is labeled Section M in the May 7 guidance.

A side-by-side comparison of current and proposed rates is not applicable, because this is an initial rate filing for new products.

Section Q below contains a list of all rating factors used. The plan design factors were developed according to the requirements of 45 CFR §156.80(d)(2). Of the permitted plan-level variations, the variation among plans is entirely due to actuarial value and cost sharing differences. Actuarial value and cost sharing differences were measured by using the HCGs to estimate the paid-to-allowed ratio and allowed claim costs for a population with standard demographics in both plan designs. By using a standard population (rather than the demographics of the projected CCHP population), we ensure that selection and health status do not affect the calculation of this factor.

CCHP has elected to employ a tobacco factor of 1.15 for all age groups.

CCHP's products are licensed in six rating areas within the state. Area factors are shown in Section Q of this memorandum. We have used eleven rating areas consistent with the recent revisions to the Colorado Geographic Rating Areas. This is not consistent with prior rating areas established in Regulation 4-6-7.

The age factors shown in Addendum A are mandated by federal regulation (see 45 CFR §147.102).

## P. Benefits Ratio Projections

This section is labeled Section N in the May 7 guidance.

The following table shows projected premium, claims, and benefits ratio for 2014. Because this is a new product, the requirement in Regulation 4-2-11 to provide this information without the rate filing is not applicable. Note that the values in this table are based on the definition of "benefits ratio" in Regulation 4-2-11. The federal MLR definition is different.

| Table 5 – Benefits ratio projection | |
|---|---|
| **Component** | **Value** |
| Projected premium, PMPM | $308.07 |
| Projected claims, net of risk adjustment receipts, PMPM | $270.01 |
| **Projected benefits ratio** | 87.65% |

## Q. Other Factors Used

The following table contains a summary of the rating factors used for these products. These are all multiplicative adjustments to the market-wide index rate of $240.90

When family coverage is purchased, each family member will be rated separately, and the sum of the individual premiums will equal the family premium, with the constraint that no more than three members under the age of 21 will contribute to the family premium.

Rating areas are those released by the Division of Insurance on March 27, 2013. Rating factors have been provided for all areas, regardless of CCHP's licensure in these areas.

| Table 6 – Rating factors | |
|---|---|
| **Factor** | **Value** |
| GoldChoice 1500/20 | 1.1149 |
| GoldChoice 1000/20 | 1.1312 |
| GoldChoice 500/30 | 1.1313 |

| Table 6 – Rating factors | |
|---|---|
| **Factor** | **Value** |
| SilverChoice 1500/50 | 1.0000 |
| SilverChoice 2000/40 | 1.0054 |
| SilverChoice HSA 1500/30 | 0.9838 |
| SilverChoice 2000/50 | 0.9636 |
| SilverChoice 3000/30 | 0.9964 |
| BronzeChoice 3000/50 | 0.7852 |
| BronzeChoice HSA 3000/50 | 0.7748 |
| BronzeChoice 5000/50 | 0.7700 |
| ValueChoice 100 | 0.7561 |
| Tobacco surcharge | 1.1500 |
| Rating Area 1 | 0.9300 |
| Rating Area 2 | 0.8700 |
| Rating Area 3 | 0.9700 |
| Rating Area 4 | 1.1800 |
| Rating Area 5 | 1.1500 |
| Rating Area 6 | 1.2000 |
| Rating Area 7 | 0.9800 |
| Rating Area 8 | 1.0000 |
| Rating Area 9 | 1.1800 |
| Rating Area 10 | 1.0500 |
| Rating Area 11 | 1.7500 |
| Age | See Addendum A |

## R. Rating Manuals and Underwriting Guidelines

This section is labeled Section P in the May 7 guidance.

There are no underwriting guidelines applicable to these products. Section K provides a complete description of how rates are developed and how they vary from one applicant to another. The “rate manual” is attached in SERFF, and contains the same information shown in Section Q above.

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries
May 14, 2013

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## Addendum A

### AGE FACTORS

Under 45 CFR §147.102, all carriers in each state must use a standardized set of age factors. There is a federal default which is to be used in states (such as Colorado) that do not set their own factors. The following are the age factors that will be used as multiplicative adjustments to the market-wide index rate.

**Table A.1 – Age Factors**

| Age | Factor | Age | Factor |
|---|---|---|---|
| 0-20 | 0.635 | 43 | 1.357 |
| 21 | 1.000 | 44 | 1.397 |
| 22 | 1.000 | 45 | 1.444 |
| 23 | 1.000 | 46 | 1.500 |
| 24 | 1.000 | 47 | 1.563 |
| 25 | 1.004 | 48 | 1.635 |
| 26 | 1.024 | 49 | 1.706 |
| 27 | 1.048 | 50 | 1.786 |
| 28 | 1.087 | 51 | 1.865 |
| 29 | 1.119 | 52 | 1.952 |
| 30 | 1.135 | 53 | 2.040 |
| 31 | 1.159 | 54 | 2.135 |
| 32 | 1.183 | 55 | 2.230 |
| 33 | 1.198 | 56 | 2.333 |
| 34 | 1.214 | 57 | 2.437 |
| 35 | 1.222 | 58 | 2.548 |
| 36 | 1.230 | 59 | 2.603 |
| 37 | 1.238 | 60 | 2.714 |
| 38 | 1.246 | 61 | 2.810 |
| 39 | 1.262 | 62 | 2.873 |
| 40 | 1.278 | 63 | 2.952 |
| 41 | 1.302 | 64+ | 3.000 |
| 42 | 1.325 | | |

# Colorado Choice Health Plans
# Individual Comprehensive Medical Business
# Rate Filing Justification
# Part III - Actuarial Memorandum and Certification

## I. General Information

### *Company Identifying Information*

| | |
|---|---|
| Company Legal Name: | Colorado Choice Health Plans |
| State: | Colorado |
| HIOS Issuer ID: | 63312 |
| Market: | Individual |
| Effective Date: | January 1, 2014 |

### *Company Contact Information*

| | |
|---|---|
| Primary Contact Name: | Cynthia Palmer |
| Primary Contact Telephone Number: | (719) 589-3696 |
| Primary Contact Email-Address: | cpalmer@cochoice.com |

## II. Proposed Rate Increase(s)

This submission is for new products available for sale January 1, 2014. Colorado Choice Health Plans (CCHP) currently has no non-grandfathered policies, certificates, or covered lives on the individual market. Because these are new products, there are no proposed rate increases as there were no prior products against which to compare these rates.

Because no prior non-grandfathered claim experience was available for this product, the Milliman *Health Cost Guidelines*™ cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of CCHP's market given underwriting, rating, and benefit requirements effective January 1, 2014 under the Patient Protection and Affordable Care Act (ACA);
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

Each of these factors is discussed in more detail later in this memorandum.

## III. Experience Period Premium and Claims

### *Claims Paid Through Date*

CCHP does not have any prior non-grandfathered claim experience. Therefore, no paid claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

### *Premiums (net of MLR Rebate) in Experience Period*

CCHP has not collected any prior non-grandfathered premiums in this market. Therefore, no experience period premium information is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

### *Allowed and Incurred Claims Incurred During the Experience Period*

CCHP does not have any prior non-grandfathered claim experience. Therefore, no allowed and incurred claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period. Premiums were developed using a credibility manual rating approach.

## IV. Benefit Categories

CCHP does not have any prior non-grandfathered claim experience in the individual market. Therefore, no claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Because no prior non-grandfathered claim experience was available for this product, the Milliman *Health Cost Guidelines* (HCGs) cost and utilization information was used in the development of these rates.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Capitation *(which was not applicable in this context)*
- Prescription Drug

## V. Projection Factors

CCHP does not have any prior non-grandfathered claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates. This section describes the projection factors we used with the HCGs to develop the credibility manual rates for the projection period.

### *Projections and Adjustments Made to the Data*

Because the process for projecting and adjusting the data used to estimate the claim costs for these products involved a number of steps that are interrelated, the entire process is described here and will be used for reference throughout this document.

Claim costs for proposed plans were developed using the Milliman HCGs, with adjustments to reflect the relative value of CCHP's individual experience compared to the Milliman HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA.

We followed the steps below to adjust the Milliman *Health Cost Guidelines* claim experience to be on an appropriate basis for premiums for CCHP.

Step 1: Project Total Colorado Market Members and Health Status by Population Cohort

We expect significant shifts in the insured population when the health insurance Exchange opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.

- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Colorado.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual and SHOP Exchanges (i.e., "take up" rates). The Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an individual Exchange plan.

We then applied employer-sponsored insurance transition rates, small group, and individual / uninsured Exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For CCHP's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and Exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

Step 2: Project CCHP Enrollment by Market, Exchange Status, and Product

We projected CCHP's expected 2014 individual product enrollment on the exchange based on our estimate of the statewide population and CCHP's likely share of the total based on our assumed price relativity and appeal. We estimated the members that would select each of CCHP's benefit plans based on the plans for which they would qualify (given their age and income level) and assumed 8% of these members

are tobacco users. We also assumed that all 2014 members are enrolled for the entire year.

Step 3: Claim Cost Projection

The basis used to develop rates for these new products is the 2012 Milliman *Health Cost Guidelines*. The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado -specific unit cost and utilization basis.

Step 4: Adjustment for Changes in Morbidity

The data in the *Guidelines* is for a large group population. We believe this is a more appropriate basis for the development of future individual premium rates than current individual claim levels because large group experience includes a breadth of covered benefits consistent with those in the Essential Health Benefits (EHBs), and the impact of selection or medical underwriting present in the current individual market is mitigated by using non-underwritten large group experience. The *Guidelines* are based on the 2012 large group population. We project that the 2014 individual market population will have a different population profile than the current large group market, and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the large group claims to represent our estimate of the market average demographics and morbidity of the 2014 individual market.

As mentioned previously, through our population modeling we developed an estimate that the 2014 individual market will have a 12.2% higher morbidity than the current large group market, and so applied this adjustment factor to increase the claim costs.

***Changes in the Morbidity of the Population Insured***

We anticipate moderate changes in the average morbidity of this market in 2014 due to ACA provisions effective in January 2014. Please see Step 4 in the "Projections

and Adjustments Made to the Data" section above for a description of the development of the adjustment factor.

The projection factor of "Pop'l risk Morbidity" shown in Worksheet 1, Section II reflects the impact of the shift in mix over time. This projection factor was calculated based on our projection from the current credibility manual experience to the 2014 individual market morbidity. Note that this factor does not include the impact of changes in demographics to ensure that demographic shift is not counted twice.

***Changes in Benefits***

The underlying utilization and charge levels assumed in the 2012 Milliman *Health Cost Guidelines* baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out of pocket maximum. Adjustments were then made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been created by studying the historical impact of different contractual limitations and cost sharing on utilization experience by the covered population.

The adjustments we used to develop utilization rates consistent with these products are as follows:

- Starting with large group experience enables us to capture the impact of removal of underwriting and pre-existing condition exclusions in the current individual market, post 2014.
- Adjusted for the difference between the current large group and future (2014) individual market average risk status. This analysis involved a study of morbidity levels and relied on CPS data. The analysis is described in Step 4 of the following section.
- Adjusted for differences in benefit designs (e.g., metallic levels).
- Adjusted for changes from mandated benefits (e.g., EHBs)

***Changes in Demographics***

We expect significant shifts in the insured population when the health insurance Exchange opens in 2014. We projected Colorado statewide population demographics and health status to help determine CCHP's share of the market. Because we are using the HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 in the "Projections and Adjustments Made to the Data" section above for more details for these adjustments.

***Other Adjustments***

Because we are using the HCGs as the basis for these premiums, there are additional adjustments necessary to put the claim experience on a consistent basis

with these products. Please see Steps 1-4 in the “Projections and Adjustments Made to the Data” section for more details surrounding additional adjustments we made.

***Annualized Trend Factors***

The utilization and cost trend factors shown in Worksheet 1, Section II are reflective of an aggregate allowed charge trend of 8.1%. This aggregate value was developed based on the Milliman *Health Cost Guidelines* and general industry knowledge regarding recent trends in medical inflation.

Separate factors for utilization and cost were developed based on relative values from the Milliman *Health Cost Guidelines*. These factors result in an aggregate value of 8.1%.

These trend assumptions are based on the utilization and cost per service trends developed from claims data for the *Guidelines*. We have reviewed these trend assumptions and believe they are reasonable for this purpose. The trend assumptions above do not include the impact of changes in demographics, benefit design, or morbidity since those are captured elsewhere in the development of the index rate.

## VI. Credibility Manual Rate Development

CCHP does not have any prior non-grandfathered claim experience. Therefore, as mentioned previously, we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates.

***Source and Appropriateness of Experience Data Used***

The base experience for the proposed plans was composed of claim costs developed using the Milliman *Health Cost Guidelines*, chosen to reflect the demographic and unit cost differences specific to Colorado, as well as CCHP’s plan benefit designs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA. The *Health Cost Guidelines* are described in sections “IV Benefit Categories” and “Projections and Adjustments Made to the Data” above.

***Adjustments Made to the Data***

Adjustments made to the *Health Cost Guidelines* to create estimated claim costs for these products are described in detail in section “Projections and Adjustments Made to the Data” in Section 5 above.

***Inclusion of Capitation Payments***

The HCGs are based on nationwide claim experience, which include a complete picture for incurred and allowed dollars. These data include relevant capitation payments as part of the underlying claim experience. We anticipate that none of CCHP's medical (non-pharmacy) costs will be subject to a capitation arrangement.

***Portion of Cost Payable by HHS's Fund on Behalf of Insureds***

Because of the cost sharing reduction (CSR) provisions, HHS will pay a portion of these costs on behalf of members. We have estimated these costs based on our estimated enrollment of CSR eligible members. We have expressed this amount as a percentage of cost, in Worksheet 2. The amount of the subsidy was calculated by projecting enrollment in each CSR silver plan. As described above, we computed the projected allowed claim costs for each cohort of individual enrollees under the assumption that the benefit design was the standard (70% AV) silver plan. We increased this projected allowed amount for the impact of induced utilization, using the factors released by CMS for the purpose of applying the federal risk adjustment formula. Then, for each CSR plan, we computed the percentage point difference in actuarial value between the CSR plan and the standard silver plan (e.g., 24 points for the 94% plan, 17 points for the 87% plan, and 3 points for the 73% plan). The product of that difference and the projected allowed claim cost equals the amount of the subsidy provided by HHS.

## VII. Credibility of Experience

CCHP does not have any prior non-grandfathered claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for the Credibility Manual rates and have given them 100% credibility weight.

## VIII. Paid to Allowed Ratio

The Paid to Allowed ratio shown in Worksheet 1, Section II of the URRT was developed as our best estimate of the impact on cost sharing. We developed allowed claim costs, and used the Milliman HCGs to develop the expected portion of claims that are covered by the plan versus the member to develop the paid to allowed ratio. The paid to allowed ratio was developed as follows:

$$\frac{Weighted\ Average\ Paid\ Claim\ PMPM\ estimate}{Weighted\ Average\ Allowed\ Claim\ PMPM\ Estimate}$$

## IX. Risk Adjustment and Reinsurance

### *Projected Risk Adjustments PMPM*

CCHP recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, CCHP must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of CCHP's plans in this risk pool.

Since differences between CCHP's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must not be included in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which CCHP's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of CCHP's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at CCHP's expected morbidity level. The difference between the market average risk pool and CCHP's expected morbidity is our estimate of what the transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

*Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected statewide risk scores (to estimate CCHP's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age / gender claim cost factors from Milliman's *Health Cost Guidelines* to produce final statewide average risk scores for each population cohort.

*Project CCHP's Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected CCHP's risk scores (to estimate CCHP's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between CCHP and the overall Colorado market. Selection refers to the health status difference between a given

carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

*Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments*

We estimated statewide claim costs (to estimate the statewide premium in CCHP's risk adjustment transfer payment) by applying the steps above to estimate the PMPM claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. CCHP is not selling platinum products, but we did assume some percentage of take-up of those plans in the marketplace as a whole.

*Estimate CCHP's Risk Adjustment Transfer Payment*

We estimated CCHP's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, CCHP's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether CCHP receives or makes a transfer payment is how CCHP's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding CCHP's expenses to the statewide average claim costs described above. Next, we normalized CCHP's risk score to the statewide average risk score and removed the portion of CCHP's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received (or paid) by CCHP. As required, risk adjustment transfer revenue was allocated to plan premiums proportionally based on plan premium.

***Projected ACA Reinsurance Recoveries Net of Reinsurance***

Carriers pay contributions for the ACA reinsurance program, estimated to be $5.25 PMPM in 2014. Consistent with the Part III Actuarial Memorandum instructions, which state that this line item must be reported net of reinsurance contributions, we have included this payment on Worksheet 1, Section II of the URRT.

We assumed the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000. We estimated this value by calibrating the claims probability distributions (CPDs) from the HCGs for each of CCHP's individual benefit plans' estimated PMPM claims costs.

Projected PMPM ACA Reinsurance Recoveries in Worksheet 1, Section II of the URRT were calculated as follows:

- (Projected PMPM Incurred Claims before Risk Adjuster and Recoveries * 12. 30%) - $5.25

Projected allocations across plans are calculated as follows:

- Allocation % for Plan X =
  Projected Plan Premium before Reins / Total Plan Premium before Reins

- PMPM Allocation for Plan X = Total Recoveries * Allocation % for Plan X

## X. Non-Benefit Expenses and Profit & Risk

### *Administrative Expense Load*

Administrative expenses were developed on a PMPM basis using CCHP's projections for costs of operating its business in 2014, including the impact of general expense inflation. The value entered in Worksheet 1, Section II of the URRT illustrates this value as a percent of the index rate.

### *Profit & Risk Load*

Profit and Risk Load target values were determined as an aggregate value for the single-risk pool based on company targets and consideration for federal MLR requirements. The value entered in Worksheet 1, Section II of the URRT illustrates this value as a percent of the index rate.

***Taxes and Fees***

The table below provides a breakdown of projected taxes and fees illustrated in Worksheet 1, Section III of the URRT.

| Projected Taxes and Fees | | | |
|---|---|---|---|
| **Item** | **% Premium** | **PMPM** | **% of URRT Index Rate** |
| Premium Tax | 0.00% | $0.00 | 0.00% |
| Health Insurer Fee | 0.00% | $0.00 | 0.00% |
| Comparative Effectiveness Research | 0.05% | $0.17 | 0.04% |
| Risk Adjustment Admin Fee | 0.03% | $0.08 | 0.02% |
| Exchange User Fee | 1.40% | $4.31 | 0.96% |
| Total | 1.48% | $4.56 | 1.02% |

## XI. Projected Loss Ratio

The projected loss ratio based on the federally prescribed MLR methodology is 80.2 %. The numerator of the projected MLR contains projected claim costs and quality improvement expenses, net of receipts from the risk adjuster, reinsurance, and risk corridors programs. The denominator consists of total premiums, net of premium taxes and regulatory fees. A credibility adjustment is then applied to account for the small size of CCHP's projected enrollment. The following demonstrates our projection of CCHP's MLR, using the federal definition but not including any credibility adjustment (which could only increase the MLR):

$$80.2\% = \frac{\$308.87\ claims + \$6.18\ QI\ expense - \$38.86\ risk\ adjuster - \$32.75\ reinsurance}{\$308.07\ premium - \$4.56\ taxes\ \&\ fees}$$

## XII. Index Rate

As previously discussed, CCHP does not have prior non-grandfathered claim experience to use to develop an experience period index rate. We used a credibility manual approach, in which the base claims did not include cost for items which are not EHBs, and therefore did not need to be adjusted for the removal of non-EHBs.

The projected index rate includes the projected claim level for the projection period, including all adjustments for trend, benefit and demographic differences. It reflects the experience for all of the products we are developing since they are within a single risk pool. The projected index rate shown in Worksheet 1, Section II of the URRT was developed as follows:

Projected Allowed Claims PMPM × % of Allowed Claims Attributable to EHB

Projected allowed claims are those after credibility adjustments, but before any adjustment for risk adjuster or reinsurance payments and/or recoveries.

*Development of Plan Level Rates*

Plan level rates are developed based on the following approach:

Adjusted Index Rate =
- Index Rate
- +/- Risk Adjustment Payment
- +/- Reinsurance Recoveries net of Fees
- + User Exchange Fees

Plan Level Rate =
- Adjusted Index Rate
- × Plan actuarial value and cost sharing value factor
- × Administrative costs, excluding user exchange fees

There is no impact due to differences in provider networks, delivery system characteristics, or utilization management practices. All plans use the same network, delivery system, and utilization management practices.

## XIII. AV Metal Levels

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed based on the CMS Actuarial Value calculator.

We did not employ an alternate methodology to develop the AV Metal Values. For several CMS Actuarial Value Calculator inputs, it was necessary to use an alternate methodology to develop the AV Metal Value. The attached actuarial certification in Appendix B includes additional detail describing these calculations.

## XIV. AV Pricing Values

The fixed reference plan selected for purposes of developing AV Pricing Values is SilverChoice 1500/50.

Plan factors were derived based on the actuarial value of these products and the age/gender mix of the standard HCG population. Note that the Silver plans have relativities that are formed based on the expected mix of enrollment in the standard plans and their associated CSR plans (73% actuarial value, 87% actuarial value, and 94% actuarial value). Negligible enrollment is expected in the Native American plan variants. The plan factors below do not incorporate

differences in morbidity; overall morbidity is reflected in other rating factors and the index rate. Plan factors are presented in the table below:

| Product | Rate Factor | URRT AV Pricing Value |
|---|---|---|
| GoldChoice 1000/20 | 1.1312 | 1.079 |
| GoldChoice 1500/20 | 1.1149 | 1.063 |
| GoldChoice 500/30 | 1.1313 | 1.075 |
| SilverChoice 1500/50 | 1.0000 | 0.837 |
| SilverChoice 2000/40 | 1.0054 | 0.849 |
| SilverChoice HSA 1500/30 | 0.9838 | 0.817 |
| SilverChoice 2000/50 | 0.9636 | 0.811 |
| SilverChoice 3000/30 | 0.9964 | 0.855 |
| BronzeChoice 5000/50 | 0.7700 | 0.705 |
| BronzeChoice 3000/50 | 0.7852 | 0.672 |
| BronzeChoice HSA 3000/50 | 0.7748 | 0.661 |
| ValueChoice 100 | 0.7561 | 0.299 |

Attachment A provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and the portion of the value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2).

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the Milliman *Health Cost Guidelines* to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

## XV. Membership Projections

Membership projections, as illustrated in Worksheet 2, Section IV of the URRT were developed by applying an assumed market penetration for CCHP to the total market size estimated as described above in Section V. Our assumed market penetration rate varies by income level.

We assume that the suite of silver and bronze products will be significantly more attractive than the gold product, and have accordingly assumed that 10% of CCHP enrollees will select gold plans, 50% of enrollees will select silver plans, and 40% of enrollees will select bronze plans. For each plan within a metal level, we assume that members will choose each of the plans at an equal proportion (for example, one-third of those choosing gold plans will choose each of the three gold plans offered).

If members were eligible for Cost Sharing Reduction plans, we assumed that they enrolled for the CSR plan for which they were eligible. For those who were eligible for the catastrophic plan due to age, we assume that 50% of those who would normally enroll in a bronze plan would enroll in the catastrophic plan.

## XVI. Terminated Products

CCHP intends to terminate all existing products in the individual market. All of these products are grandfathered plans.

## XVII. Plan Type

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT.

## XVIII. Warning Alerts

The following provides additional information regarding differences between the sum of the plan level experience and projections in Worksheet 2, Sections III and IV of the URRT and the total experience and projected amounts found on Worksheet 1 of the URRT:

1. A warning is found in cell A82. This appears to be due to a very minor Excel precision error, as the actual difference between the two cells being tested is $12 out of $49,526,267.
2. A warning is found in cell A99. We believe this is an error in the template's warning alert. The difference between the two cells being tested is $71.61, which is exactly the amount of CCHP's projected reinsurance and risk adjuster receipts. The instructions for this section state that the amounts entered in row 86 (Total Allowed Claims) "should be consistent with the total allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries entered in Section III of Worksheet 1." The test, however, compares this amount (net of reinsurance and risk adjustment) with an amount on Worksheet 1 that excludes reinsurance and risk adjustment.

## XIX. Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the management of CCHP. To the extent that it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum may be materially affected.

## XX. Actuarial Certification

I, Mary van der Heijde, am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of Colorado Choice Health Plans (the "Company").

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan specific premium rates. The allowable modifiers used to generate plan specific premium rates were based on the following:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the Essential Health Benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents Essential Health Benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.

I certify that the benefits included in CCHP's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Colorado benchmark plans.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Signed: 

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries

Dated: May 14, 2013

## Attachment A – AV Pricing Value Breakdown Summary

| Plan | AV Pricing Value | Adjust 1 AV/Cost Share | Adjust 2 Network | Adjust 3 Other Benefits | Adjust 4 Admin Expense | Adjust 5 Catastrophic | Total |
|---|---|---|---|---|---|---|---|
| GoldChoice 1000/20 | 1.1312 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| GoldChoice 1500/20 | 1.1149 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| GoldChoice 500/30 | 1.1313 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 1500/50 | 1.0000 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 2000/40 | 1.0054 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice HSA 1500/30 | 0.9838 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 2000/50 | 0.9636 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| SilverChoice 3000/30 | 0.9964 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice 5000/50 | 0.7700 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice 3000/50 | 0.7852 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| BronzeChoice HSA 3000/50 | 0.7748 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |
| ValueChoice 100 | 0.7561 | 80.0% | 0% | 0% | 20.0% | 0% | 100% |